

No 5573.149

No. 135

1924





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JUN 28 1924

U. S. DEPARTMENT OF LABOR
JAMES J. DAVIS, Secretary
CHILDREN'S BUREAU
GRACE ABBOTT, Chief

HABIT CLINICS FOR THE CHILD OF PRESCHOOL AGE

THEIR ORGANIZATION
AND PRACTICAL VALUE

BY

D. A. THOM, M. D.



Bureau Publication No. 135



WASHINGTON
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LETTER OF TRANSMITTAL.

U. S. DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, November 26, 1923.

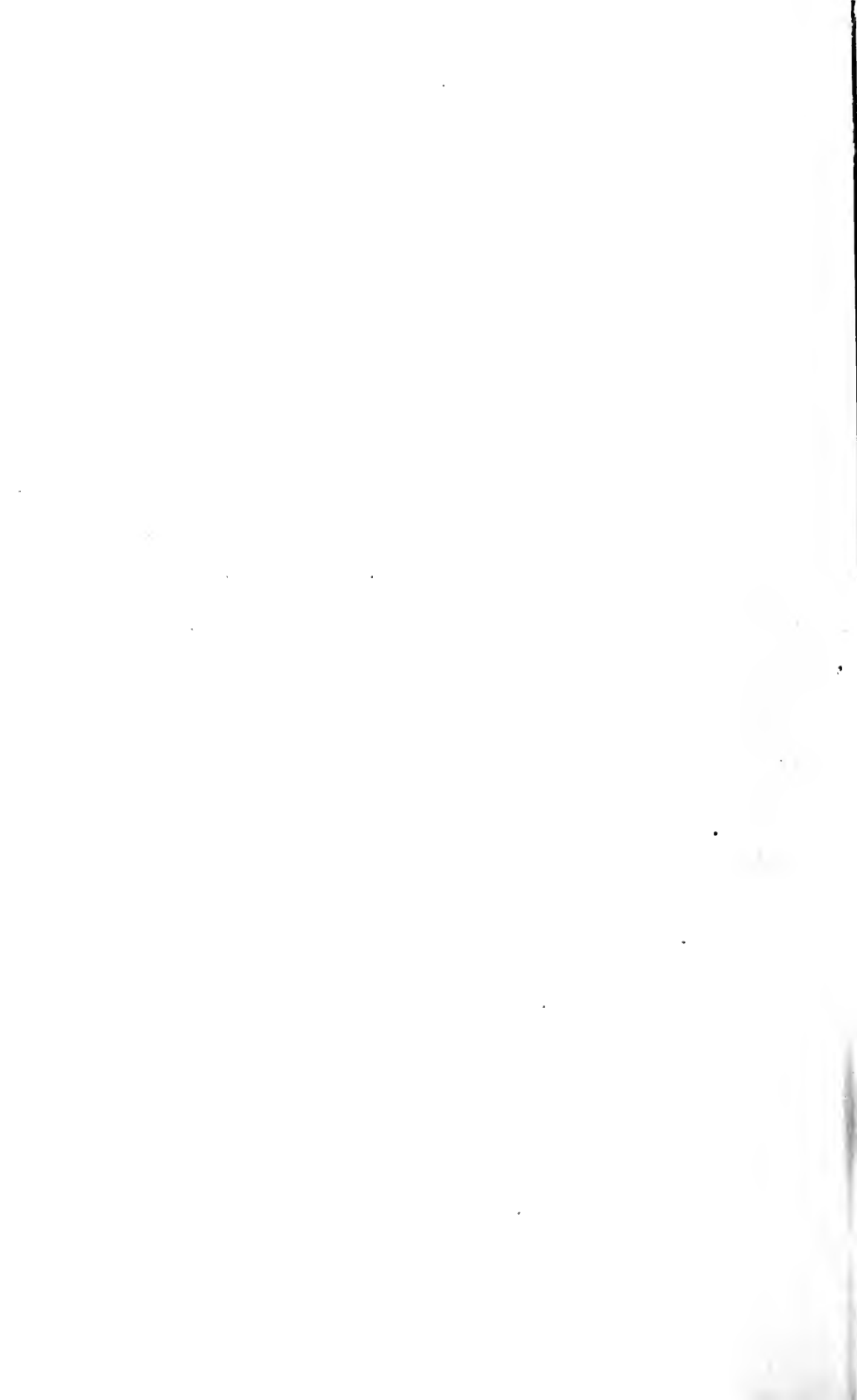
SIR: There is transmitted herewith a report on Habit Clinics for the Child of Preschool Age: Their organization and practical value, by Dr. D. A. Thom, director of the habit clinics of the Community Health Association of Boston and director of the division of mental hygiene in the Department of Mental Diseases of Massachusetts.

The preschool period is the habit-forming period for children, and it is believed that the method which has been developed by Dr. Thom and which is here set forth will be of interest to all those concerned with the physical and mental health of children.

Respectfully submitted.

GRACE ABBOTT, *Chief.*

Hon. JAMES J. DAVIS,
Secretary of Labor.



HABIT CLINICS FOR THE CHILD OF PRESCHOOL AGE.

ORGANIZATION AND DEVELOPMENT OF HABIT CLINICS.

It is not the purpose of this report to serve as a treatise on the treatment of the mental life of the child. Neither will it be considered within its scope to discuss extensively or speculate deeply or fantastically, a practice common at this time, on the possible mechanism directing the forces that result in undesirable habit formation. There is a demand for a presentation of this subject of the mental life of children in just such a form as Doctors Holt and Howland, for example, have presented diseases of infancy and childhood, but those who are best qualified are most reluctant to undertake the task. The subject of this report is the organization, method of work, and practical value of the habit clinics conducted by a small but well-trained staff as a part of the health service for children of the Community Health Association of Boston.

The objective in this discussion of the cases presented will be not what *might* be the cause of the symptoms present, but what is the most probable cause. The discussion will therefore be open to the criticism of being rather superficial and lacking in the precise technique necessary for the adjustment of the more complex situations. But in only a very small percentage of the cases coming to the clinic during the last year would the above criticism be justified. The director has felt that for the moment at least, one must consider the rule and not the exceptions. The outstanding question is how the clinic can best serve the hospital to which it is attached, the section of the city where it happens to be located, or perhaps the social agencies of the small cities which are dependent upon it for advice and treatment, in rather a large group of problem cases concerned with children. Physicians in private practice may demand a daily conference for 6, 12, or 18 months. It is unreasonable, however, to maintain, as does the ultrascientific group of workers, that nothing short of such intensive work is worth while.

In the organization and development of clinics it is necessary to be, above all, practical, in order to evaluate properly the situation to be confronted. It is not unusual for a physician, social worker, or nurse to complicate a home situation rather than to help it unless the family is kept in mind as the unit rather than the individual. For example, it may be much less effort for the mother of five children to wash extra sheets three or four times a week than to bring the youngster afflicted with enuresis to the clinic the same number of times. On the other hand, much may be accomplished with only the minimum of inconvenience to the mother if a weekly visit is made. Without minimizing the value of intensive work or giving the impression that one method will be applicable to every case it may,

however, be pointed out that many of the problems presented at the habit clinics have been treated successfully by directing attention to that which is obviously wrong in the environment, and that, too frequently, a pick and shovel are used—so to speak—when a rake would do the work just as well. It is well to add that what may be quite obvious to the well-trained psychiatrist might easily be overlooked by parents, nurse, or even the family physician.

For example, not long ago the writer was called in consultation to the home of a well-to-do family whose maid had been suffering for a week with a spasmodic contraction of the diaphragm, and at each expiration she emitted a peculiar barking noise. The patient had been carefully examined by the family physician, and a throat specialist had been called in, but the condition had persisted. The family and the patient's sister and two of her friends were all much concerned about her condition. One of her friends, a nurse, was in constant attendance. On her stand near the bedside stood a bottle of mineral water, a large dish of fruit, and considerable reading matter, and she had been surrounded with everything which might add to her comfort. The patient herself did not seem to be much concerned about her difficulty; in fact, one felt that the situation was rather pleasant than otherwise. The situation was discussed with the patient, and she was told quite frankly that her condition was of purely nervous origin and a condition which she was not to blame for having, but which, on the other hand, could be cured easily with her help. Arrangements were then made for the patient to be kept in absolute isolation excepting for the visits of the doctor, to have no nurse in attendance, and to be kept on a light diet until she was cured. The family and those interested in the case having been assured that there was nothing about which they should be concerned, the patient was left to meditate on the possibility of having to go to a hospital the following Monday if she were not able to go to work. This patient was first seen Friday evening, and Monday morning she resumed her duties in the household, completely well. This is the type of case in which the treatment was serving as a motive for the exaggeration and perseveration of psychogenic symptoms.

An irreducible minimum should be outlined for the formal examination of every case, which would consist of a report by the social worker and one by the psychologist and a personality study by the psychiatrist. These will give a fair idea of the child's mental equipment and the environment in which he is being developed and the results of the interaction of these two—that is, the inherent endowment plus the social heritage which may be evaluated in terms of personality. It is not, however, from these more formal contacts that the most valuable information regarding the child is obtained but rather from the home, the nursery and the nursery school, the settlement house, and the community center. It is here that the child is quite at ease and free from the inhibitions associated with his visit to the clinic. The strange and the new excite in most youngsters either curiosity or fear, and when either of these feelings predominates it covers up other psychological reactions of great value.

The staff of a clinic, as has been intimated, should include a psychiatrist who, under the plan being outlined, can study two new cases

each half-day per week that he devotes to the clinic, and also one social worker on full time who will be able to make satisfactory reports on six new cases each week, and a psychologist, on halftime, who can keep up satisfactorily with the rest of the clinic. Certain volunteer assistance, which is usually available and always acceptable, permits more intensive study on selected cases. A stenographer is needed on a full-time basis. The approximate cost of such a unit would be as follows: Psychiatrist, three half days per week, \$1,800; social worker, full time, \$1,800; psychologist, half time, \$1,000; stenographer, full time, \$1,200. The overhead expenses depend largely upon the local situation but can be reduced usually to a minimum when the clinic is attached to some organization already operating.

One must bear in mind that in any effort to determine the cost of operating such a clinic as we are discussing the family rather than the individual is to be taken as the unit. In the treatment of a problem child invariably the mother has to be considered as a patient, and it is frequently desirable for her to make visits to the clinic even without the patient. It has also been found that often it is not the child that has been brought to the clinic who needs treatment most, but one of the other children in the family, so that three or four members of the same family may be receiving treatment at the same time, and in every case the benefits derived by straightening out some maladjusted individual are shared by every member of the household. This point of view will alter to a considerable extent the attitude of those who are responsible for financing such a clinic and will alter their point of view on what appears to be a rather exorbitant cost per patient.

It is extremely important at this time to point out the necessity of taking the clinics to those who need them most rather than demanding that they come to the more formal medical centers, such as dispensaries and out-patient clinics. Experience has convinced the writer that only a very limited number of the cases seen at the habit clinics located in the various sections of the city would have made the effort to go outside their own district for advice on mental health. The subject, to these people, is still too vague and ill-defined for them to make the same effort to go to the clinic seeking advice on mental health that they would to go to a hospital to have a painful boil opened and drained. The ideal connection is association with some well-organized health movement for children, into which the mental clinic can fit and in which it can become a part of the routine medical work instead of being held up as a piece of "highbrow" experimental research which has not yet justified its existence. Mental clinics should go hand in hand with feeding and posture clinics, and cases should be referred back and forth as occasion demands. This medical background is absolutely essential to the clinics interested in mental health, as every case must have a careful physical examination. All organic conditions must be eliminated before symptoms can be attributed to psychogenic causes. There is no branch of medicine in which greater care is needed to prevent the introduction of all sorts of quacks than psychiatry. The association of the clinic with a recognized medical organization stamps its work as being a part of a medical program.

The time is probably not far distant when all the larger social agencies will find it necessary to operate their own clinics, at least in part. Already many such agencies are employing one or more physicians on a full-time basis, and others are doing special work on a fee basis. When the clinic idea for social agencies has developed a bit more, there is no doubt that mental health will be one of the first considerations of social agencies, for they are in a position to appreciate more keenly than any other group the importance of this branch of medicine.

Time has been taken to touch upon the more important aspects of the organization of the habit clinic, as almost daily some one writes to ask about some particular feature of the work, such as: How it is supported; how much it costs; how many cases come each month; whether the clinics should be attached to hospitals; whether there must be beds connected with the clinics; who refers the cases; how long they are treated; whether they are given medicine; whether they are treated as individuals or in groups; whether the parents come to the clinics; whether the doctors go to the homes; and whether or not the children have physical examinations.

HABIT-CLINIC PROCEDURE.

It may be of interest at this point to take up in some detail the exact procedure followed at the habit clinic in making contact with new cases.

The children who are seen at the habit clinic have been referred to a very large extent by the visiting nurses of the Community Health Association, the dietitians and physicians who see the cases at the health clinics, and teachers in the kindergartens; and not infrequently they are brought directly to the clinic by parents who have been encouraged to come by some relative, friend, or neighbor who has utilized the clinic.

During the first week of October a visiting nurse, entering the home of Mrs. S, finds the mother very much upset, nervous, and agitated on account of having been worried all day by her little daughter, Mary, aged 2 years and 2 months. Casual inquiry at this time reveals the following facts: The child is extremely disobedient, almost to the point of being negativistic, absolutely refuses to respond to a direct command, and can be managed only by constant coaxing. Although Mary was weaned months before, the mother has resorted to the use of the bottle in order to comfort her before she takes her nap and before she goes to bed at night and also to help in getting sufficient nourishment into the child to keep her from losing weight. At every meal the mother is put through the trying ordeal of feeding the child herself, carrying the food from the plate to the child's mouth, and then often being rewarded for her efforts by having the child spit it out on the floor. It is also mentioned quite incidentally that the child wets the bed every night and has done so ever since the mother resorted to the use of the bottle some months before.

With this information at hand, the nurse reported the situation to the supervisor in charge of the settlement house where a clinic was being held, having previously interested the mother in the habit clinic and what it is trying to do for just this type of case. The

supervisor then referred the family to the social worker of the habit clinic, who, within the next two or three days, made a careful social investigation of the home. The following is a brief summary of her report:

SUMMARY OF SOCIAL WORKER'S REPORT.

CASE OF MARY SMITH.

Date of investigation, 10-6-23.

The family live on ——— Street, Roxbury, in a very poor and crowded district. The street is narrow, unpaved, and cluttered with papers like an alley. There are three-story brick tenement houses on each side, and one has the feeling that it is a congested neighborhood, as the street is crowded with children; there is a great deal of noise, and many people are hanging out of the windows.

Patient's family, consisting of father and mother, patient, aged 2, and a little girl of 6 months, occupy a 4-room tenement with bath, on the third floor, for which they pay \$20 a month. The home is very clean and neatly and prosperously furnished. There is a living room, a dining room, a kitchen, and a bedroom. All members of family sleep in one room. Patient has a crib by herself.

The mother is a slight, delicate young woman of 20, who enjoys housekeeping and is very much interested in her home. She went two years to high school, then worked as a clerk before marriage, and has been married three and a half years. She has a bad temper and is easily excited. She told worker that when patient does not mind her immediately, she becomes impatient and "feels all stirred up inside."

The father is a short, well-built man of 24, who drives a garbage truck for the city, earning \$24 a week. He is in good health, is interested in his home, and plays with his children. He and his wife differ in regard to discipline, he often telling the child that she can do things which her mother has forbidden.

Patient was born August 2, 1921, full term, instrumental; one eye was black and blue. Development was quicker than that of the average child. First tooth: Four months. Walking and talking: Under a year. Patient has had no diseases or convulsions. The only evidence of illness is that three weeks ago she had a fever of 103 and was nauseated.

Habits.—Sleeps from 6.30 p. m. to 6 a. m. Is restless and occasionally cries out for mother in her dreams, awakens, but goes back to sleep again. No night terrors. Has a two-hour nap in daytime.

Feeding.—She is not finicky but has a capricious appetite. At different times refuses different foods. Always has to be coaxed and occasionally spits out her food. Will not drink milk except from a bottle. Is always given one when put to bed.

Enuresis.—Wets bed every night.

Disposition.—Affectionate; demonstrative; generous; not jealous, pugnacious, nor domineering; very stubborn and inclined to be negativistic. Always has to be coaxed to do things; is very disobedient.

Play life.—Enjoys playing with other children but can amuse herself if left alone. Likes dolls.

Summary.—There is no evidence of nervous or mental disease in the family. The chief problems are refusal of food, enuresis, and disobedience. The mother is excitable and easily loses patience with the child. The father seems sensible, but parents conflict in regard to discipline.

The mother was asked to report with the child at the clinic at 9 o'clock on the morning of October 10, when the child was immediately taken in charge by the psychologist, whose report is here summarized.

SUMMARY OF PSYCHOLOGIST'S REPORT.

Some 15 or 20 minutes before the psychological examination was begun friendly relations were established. The child, after an initial hesitancy and shyness, quickly became interested in playing and enjoyed especially the

drawings of a cat with long whiskers. As she is of that age where best examination results are obtained with the mother present, provided she use discretion, the mother was given the usual instructions as to how she could help in the examination. The mother was quite interested, and excellent co-operation was secured. She smiled encouragement from time to time and did not let Mary know when a failure had occurred. She wisely refrained from distracting her by urging her to do better.

Mary showed but slight hesitancy about entering the examination room. As soon as she saw the pictures and the colors her self-consciousness disappeared. The tests given her were presented as games and she quickly caught the play spirit and very willingly tried to do everything which was asked of her. The mother, too, was pleased and incidentally quite surprised that the youngster did things which she had never tried before.

Mary is 2 years and 2 months old. She developed rather more quickly than the average child, getting her first two teeth at 4 months. She said such things as "mama" and "papa" at 6 months and a large number of words plainly at 9 months.

As far as formal tests are concerned, this child made a very good showing. She did satisfactorily all but one test that the average child of 2 does. Pictures took her eye, and she interestedly pointed to objects in the pictures and named one or two in each. She quickly imitated such movements as raising arms and clapping hands and quickly carried out simple requests such as "Bring me that ball," "Now throw it to me," and "Go over there and sit on that chair." Before eating a piece of candy, she removed the paper in which it had been wrapped. Her one failure, in the 2-year test, was that of copying the circle with a pencil. As her mother has never allowed her to use a pencil lest she mark up the house, this failure is insignificant. She passed four of the 3-year tests. She knew her full name, her sex, and took delight in pointing out her eyes, nose, mouth, and hair. She pointed to shoes, stockings, and dress and was familiar with the names of common objects, such as pennies, knives, keys, a watch, and a pencil. In all informational questions she did exceptionally well.

Summing up results, we find that Mary has a mental age of 2 years and 6 months, as against an actual age of 2 years and 2 months, which gives her an intelligence quotient of 116. Her developmental history, her general alertness and interest in things about her, her quickness in learning, and her rating on formal tests show a child above the average in intellectual equipment.

INTERVIEW WITH PSYCHIATRIST.

Shortly afterwards the mother was interviewed by the psychiatrist, and although the following conversation was not taken verbatim it represents what was said as nearly as can be remembered from the notes dictated a few hours later:

DOCTOR. I understand from Miss W, who visited you the other day, that Mary is becoming quite a problem.

Mrs. S. She is, indeed. I hardly know what to do with her. She refuses to eat anything, and she gets me so worked up and so tense inside that I go into hysterics.

DOCTOR. Then perhaps you are not feeling very well yourself.

Mrs. S. I am feeling all right now, but at times I get nervous.

DOCTOR. Under what conditions are you most apt to get worked up, Mrs. S?

Mrs. S. Usually when I have had arguments with my husband regarding Mary—how to make her mind and what I should do. When I am trying to make her mind or take her food, he butts in and says, "Let her alone. Don't keep bothering the child." And on other occasions when she is doing things that he doesn't like, he asks me why I don't make her mind.

DOCTOR. One may assume from the report which Miss W brought to me that you and your husband get along very well, that you are both fond of and very much interested in Mary, and that you want to do everything possible to have her overcome these undesirable habits.

Mrs. S. Yes, sir. Mary is the only thing over which we have any arguments at all, and we both want to do all we can to help her.

DOCTOR. You know, Mrs. S, that a child of Mary's age, especially a child of Mary's intelligence, has a very much better understanding of the ordinary things going on about the household than we give her credit for. It is sur-

prising how early a child learns that there is some doubt in the minds of her parents as to just what is right and what is wrong, and, quite naturally, when there is any doubt in the child's mind as to what course he is to follow, he is very apt to take the easiest one, so it is extremely important that you and Mr. S get together and have a definite understanding as to what you are to expect of Mary. You know, too, that not infrequently parents are apt to discipline children in a rather erratic way. I mean by that that much depends upon how the parent happens to be feeling at the time the child needs discipline. If the mother is in a cheerful state of mind and not tired out by the household duties, some breach of discipline may be looked upon as quite amusing, and the parents may speak of it as "cute," and the mother may laugh at the child instead of reprimanding her. On the other hand, if the same thing happens at the end of a hard day when the mother is worried and annoyed and somewhat out of temper herself, the child may be punished and sometimes punished severely and out of all proportion to what she deserves. Of course, you understand that I don't mean that is the method used in your home, but it is a method that is used in most homes, more or less, and I just mention it so you will understand better what I mean by the importance of getting together with your husband and talking these matters over.

Mrs. S. Yes, I know lots of mothers who do just that—laugh at the baby as "smart" one day and slap him for the same thing the next.

DOCTOR. I would also call your attention at this time to something that you probably already know and that is that it is very bad for the child to have the parents question each other's methods of discipline before the child. It is much better to have the mother or father carry out her or his own method even if the other parent is not in full agreement with what is being said or done and then discuss the whole thing in private after the child has gone to bed. It is only in this way that the child learns that the parents are united in their efforts to bring about the desired manners and habits. I think it is of the greatest importance that you talk these things over with your husband and have an agreement which will prevent any discussion of authority before the child.

Mrs. S. Yes, sir; I see exactly what you mean.

DOCTOR. Now we will discuss the feeding problem. I understand that Mary has not as yet given up the bottle.

Mrs. S. I had her weaned from the bottle, but she absolutely refuses to take milk from the cup. It was only when I put a little water with it that I could get her to drink it. I took her to the doctor, and he said if she wouldn't take milk from the cup, to let her have it from the bottle, and that is what I have been doing the last few months. She gets the bottle every morning at 10 o'clock when she takes her nap and every night when she goes to bed.

DOCTOR. Of course, you appreciate the fact that Mary is old enough to give up this bottle and that her clinging to these habits so strongly simply represents a desire on her part to stick to those infantile methods which she should be gradually giving up. The feeding problem, and the bed wetting as well, represent habits which are quite normal for infants but which she should have outgrown some months ago, and it is going to be a great deal easier to break her of these habits at 2 years of age than it will be at 4 or 5. There is no better time to begin than the present.

Mrs. S. I realize all that and am willing to do whatever you say.

DOCTOR. Tell me a little about other difficulties with feeding which she has.

Mrs. S. She absolutely refuses to take any food unless I feed her.

DOCTOR. You mean by that you have to sit down beside her at each meal and actually take the food from her plate and put it in her mouth.

Mrs. S. Yes, sir; and she even spits it out.

DOCTOR. Then mealtime must be a very trying experience for you.

Mrs. S. Yes, sir; it is the worst time I have.

DOCTOR. Then let me tell you what I have learned from my experience regarding these children who cause so much difficulty by refusing food. In the first place, we must remember that it is a very natural thing for all human beings to crave attention, and this is particularly true of children. The refusal of food is frequently a method that children use to get the time and attention of the parents. At that time they become the center of attention, and it is a battle of wits between the mother and child to see which one will win. The mother frequently puts the food on the table with serious

doubts and misgivings in her own mind as to whether the child will eat it or not and perhaps her first remark is, "You have got to eat this. You are not going to get up from the table until you do eat it. You didn't eat any breakfast, and you can not go out to play until you have eaten your lunch." This immediately puts the child in a rather defiant mood. Even if it had not occurred to the child to refuse his food, this in itself acts as a challenge. It is just as though there were a little play going on, in which the child is taking the leading part—a situation in which both children and adults like to find themselves. We know that the child knows that invariably, if he does not eat his meals at the regular time, the anxiety on the part of the mother will make her only too willing to provide food between meal hours. So in this way the child is not only able to defy the parent and attract attention and win his battle but he is also able to get the amount of food which his system requires. It may be that he doesn't get the best type of food and the kind best suited to nourish him, but he gets the food which pleases him most and satisfies his hunger, and that is about all the child wants.

Mrs. S. But, Doctor, if I let her go without her meals she will get so thin.

DOCTOR. It will be hard at first, I know, but I would suggest that from now on, or at least during the next week, you and your husband agree to the following plan: Place on the table a smaller amount of food than you would naturally want the child to eat; this should include milk, cereal, fruit, and whatever else you may wish her to have, and absolutely nothing should be said regarding the food itself or the child's eating it. If the child is eating with you and your husband, pay no attention whatever to her eating; after you have finished and sufficient time has been given the child to eat her food, remove the dishes and say nothing at all regarding the amount of food the child has eaten. If Mary has not been in the habit of having milk between meals, under no circumstances give it to her.

Mrs. S. She has been having the bottle at 10 o'clock, just before she takes her nap.

DOCTOR. Then, under those conditions, I should give her an equal amount of milk in a cup. On the way home, I should drop into the drug store and get half a dozen straws and let her use those during the coming week. It will be a step away from the bottle and will interest her in taking the milk from the cup.

But to continue regarding the more general statements as to her feeding habits. Do not be concerned if she does not eat much for the first few days. It will take a day or so for her to learn from your apparent lack of interest in her eating that no one is very much concerned whether she eats or not. In other words, try to get away from romance at her feeding periods as much as you can. Mary will soon find that she no longer occupies the center of the stage during the meal hour. I appreciate that you will be just as concerned, but the important thing is not to let Mary know it. The task I have outlined is a difficult one, I know, but it is not anywhere near so difficult to manage now as it is going to be a year or two from now; and although the results may be discouraging at first, you may be assured that in the end it will work out not only to Mary's advantage but to your own.

Mrs. S. Well, I'll try this week and see if I can stand it.

DOCTOR. I don't want you to look for improvement to-day or to-morrow or the next day, but I want you to think ahead three or four months and then picture Mary eating in a perfectly normal, healthy way without causing you or the rest of the family any disturbance. The only way to do this successfully that I know of is to follow the plan that I have just outlined.

It is absolutely essential that you and Mr. S work together on this matter, because if you do not cooperate the whole plan is doomed to failure, and this first victory for Mary may work out to her disadvantage in later life. I am sure you know many people your own age who are terribly finicky about what they eat, having all sorts of digestive upsets, refusing to accept any suggestion made by others—the type of person who is generally disliked and hard to get along with. It is just such people as these that children with all sorts of finicky habits are quite likely to develop into.

Mrs. S. I certainly wouldn't like Mary to grow up like an old woman who lives near us. She's just like that, and nobody can stand her.

DOCTOR. Do you think you will be able to carry out the plan I have outlined? I mean by that, do you feel that you will have the courage to let Mary go for a few days without what you feel is a sufficient amount of food in order to make her appreciate the fact that whether she eats or not is a thing which primarily

concerns herself, and that going without food is not going to develop a tremendous upset in the home?

Mrs. S. I think I see what you mean, and I surely will make every effort to carry out your instructions and get my husband to also.

DOCTOR. Now let us consider the problem of enuresis. I understand that Mary wets the bed practically every night.

Mrs. S. Yes, sir; every night. It has been much worse since she has been getting the bottle just before she goes to sleep.

DOCTOR. Now as the time is getting short I want to outline a plan for that with less explanation than for the feeding problem, as I think this is a much more mechanical thing and will respond to treatment more easily.

Mrs. S. I have whipped and whipped her, and as it does no good I have given it up as useless.

DOCTOR. You were wise in giving up whipping her for this habit because she is undoubtedly in no way to blame for it, and it is quite an injustice to whip children for things over which they have no control.

Mrs. S. I agree to that.

DOCTOR. Now, what time does Mary usually go to bed?

Mrs. S. At 6.30.

DOCTOR. And what time does she have supper?

Mrs. S. At 4.

DOCTOR. Then I would suggest that you follow out in detail this plan. Let Mary have her supper at 4 o'clock, with such liquids as she is in the habit of taking, bearing in mind the fact that she is to take the milk from the cup and not the bottle; between 4 and 6.30 o'clock she is to have no fluids whatever. Before going to bed she is to be taken to the toilet, and you must see that she passes her urine. When she is put to bed make her understand that she is to be taken up later on in order to prevent her from wetting the bed. What time do you go to bed yourself, Mrs. S?

Mrs. S. At 12 o'clock.

DOCTOR. Do you mean that you go to bed every night at 12 o'clock?

Mrs. S. Yes, sir.

DOCTOR. Isn't that rather late?

Mrs. S. Well, after supper my husband listens in on the radio until about 10.30. Then I make tea, and we have a little lunch, and by the time I get the dishes cleared away it is about 12.

DOCTOR. Then I would suggest that you make a tour of inspection every hour in an effort to determine at just what time Mary wets the bed, and that at 10 o'clock, three and one-half hours after she has gone to bed, you get her up, thoroughly awaken her, and take her to the toilet, being sure that she realizes why she has been awakened; that is, that it is in order to prevent her from wetting the bed. It is important that you do not pick Mary up in a semi-drowsy state and simply place her on the toilet; she must be awakened thoroughly and given to understand exactly why you have awakened her. Then you can put her back to bed and allow her to remain until your husband gets up in the morning, which I presume is about 6 o'clock.

Mrs. S. Yes, sir.

DOCTOR. I am sure that if you follow out the instructions I have outlined regarding feeding and bed wetting, you will return next week and be able to report considerable improvement.

Mrs. S. I hope so, sir, for it makes me so much extra work to have her go on this way.

DOCTOR. Before you go, I want to remind you again of the most important and fundamental thing that I have said this morning, and that is that you and your husband discuss this matter of discipline openly and frankly and decide upon a plan which will insure cooperation. It seems only natural, inasmuch as you see more of the child than your husband, that the discipline should be in your hands and that he should support you and help you follow out the plan that you agree upon. Under no condition allow Mary to feel that there is any disagreement between you two as to what it is best for her to do. As soon as she finds out that the household is divided against itself the battle, so far as you and your husband are concerned, is lost, and a great injustice is done to Mary.

I see by the tests that have been worked out this morning that Mary is a keen, bright little girl of unusual intellectual equipment, which means that she will be all the more capable of taking advantage of any failures which you or your husband make.

You may be assured we will do everything possible to help you out during the next few weeks, and there is every reason to believe that by Christmas time Mary's difficulties will be well settled. Can you arrange to come back a week from to-day?

Mrs. S. Yes, sir.

Doctor. Then that will be all this morning, except that I should like to get just a bit acquainted with Mary before you go, but the problem of correcting her undesirable habits will have to be solved very largely by you rather than by Mary.

The mother brought the patient into the examining room, but no effort was made on the first visit other than to make friendly contact with the patient, who appeared to be a bright, keen little girl, well developed, and fairly well nourished. She seemed interested in everything in her environment. In running about she fell down and knocked against a chair hard enough to hurt herself considerably. She immediately began to cry, but it was not difficult to attract her attention to something else, and the tears did not last long. Her attitude in the clinic during the short period of observation revealed nothing that had not been brought out by the social-service and psychological reports.

Had this child been one year older, with her rather superior intelligence, an attempt would have been made to interest her in keeping a record of her success regarding both feeding habits and enuresis. She would have been given a chart such as the accompanying one, and every effort would have been made to arouse her interest in obtaining as many stars as possible on her chart, which she would bring to the clinic the following week. Not only can the chart system be made a matter of great interest to the child, but it also serves as a detailed record of what has been done during the clinic intervals. That is, instead of having the parents report that the child has done pretty well or poorly regarding such problems as feeding, enuresis, and temper tantrums, we have a very definite quantitative record of exactly what success has been attained.

The chart system has been criticized by some on the basis that it savors of bribery, but there is no reason why the child should be denied some visible evidence of approbation of his efforts. Neither is there any reason why such efforts should not be rewarded if conditions permit. The incentive for most efforts, in either children or adults, usually resolves itself into a striving for approbation or reward and it is rather far-fetched to deny children the same approbation that most adults are seeking.

The following chart shows how the record is kept:

NAME: *Sally Jones.*

OCT. 5 to OCT. 12.

EVERY STAR MEANS SUCCESS IN EATING MY MEALS.

Breakfast

Dinner

Supper

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

However, it is not feasible to utilize the charts for Mary, as they are beyond the comprehension of a child 2 years old; but with the cooperation of the parents, who are keenly interested and who have

at least average intelligence, there is every reason to believe that the problem at hand will not be particularly difficult and that success will be attained within a month or six weeks. It will be necessary, however, to keep in close contact with the patient and her parents for a longer period in order to keep up the educative methods started and keep the child from slipping back into the undesirable habits.

An effort has been made in the foregoing paragraphs to give the reader a fairly good idea of exactly what takes place during the first visit of every case to the habit clinic. It matters not whether the problem is one of enuresis, feeding, or masturbation, or whether it is some of the more difficult personality defects—such as jealousy, shyness, cruelty, or abnormal fears—extreme tact and diplomacy are needed, in order, on the one hand, not to offend the parents, and, on the other hand, to impress them with the importance of the mental side of the child's life. They invariably feel that they have used all the patience and good judgment that might be expected from any one in handling the problem with which they are confronted. Thus it is necessary to generalize and speak in a more abstract way on the first visit than after working relations have been established and the parents have developed confidence in the clinic. It is essential in conversing with parents to explain the points made by examples which are well within their comprehension. Care must be exercised not to criticize harshly or unjustly, and it must ever be borne in mind that the interest of physicians is primarily therapy and not science or morals.

THE SOCIAL SERVICE OF THE CLINIC.

The social work in the habit clinic is complex and varied. Like all social work, "it is concerned with all aspects of life and with all human relationships," for it deals not only with the children but with their parents, grandparents, and in fact with everybody and everything with which they come in contact. The method is, as Miss Jarrett describes it:¹ "(a) Examination of the past life and present condition, by means of data secured through investigation and observation; (b) analysis of these facts to determine the fundamental causes of the trouble; and (c) a plan of treatment by which all the elements of the individual's life are so organized as to effect the best adaptation to his environment that is possible for him." The purpose of the clinic is to observe and understand the child as a person and to seek a real explanation of his conduct in terms of his desire and feeling, rather than to pass judgment upon him according to his conformity—or rather nonconformity—to adult ideals and standards, and having gained some insight into the child's personality, to help the parents, relatives, and all persons associated with him to see his difficulties in an understanding way and to have a normal, helpful attitude toward him. The social worker's purpose is to contribute both to the understanding of the child and to the carrying out of the treatment.

¹Jarrett, Mary C.: "The educational value of psychiatric social work." *Mental Hygiene*, Vol. V, No. 3 (July, 1921), p. 512.

The social work is both practical and educational. The worker is responsible for the admission of new patients to the clinic. She must make the contact in the home, study the child under normal conditions, secure a complete social history (including information from hospitals, agencies, schools, and other sources, as well as from the parent), and insure attendance at the clinics.

At the clinic the child is given a psychometric test before he sees the psychiatrist. The psychiatrist has all the above data at hand (written up according to outline) when he examines the child. After a consultation with the patient and the parent, the doctor, social worker, and psychologist decide upon a plan of treatment. The social worker's duties are then to carry out this plan, making the necessary adjustments in the environment and insuring the cooperation and understanding of the patient and parents as well as that of all other persons associated with the case.

The educational work goes hand in hand with the practical from the very beginning, when the case is first referred by an outside agency, to the end, when the child is finally adjusted to his environment. The work of habit clinics is so new that the worker has to sift the cases which are referred, explaining to various agencies and individuals the kind of problems that are suitable for the clinics, the reasons why certain habits are serious, and the importance of various conditions which by the lay person are considered self-eliminating or inconsequential but which may cause serious trouble to the child and affect adversely the development of his personality. It is most important to educate the parents in this respect, and in this task the worker must use all her technique, tact, and caution. It is a very delicate piece of work to deal with a parent who has been a failure with her child (for this is often the case), especially if one has to point out the seriousness of the difficulty as well as the difficulty itself. It is in this respect that the habit clinic differs from most other agencies. Hospitals, schools, and many other organizations have the law behind them, or if not the law, the fear of death or destitution, or an actual and conscious want, and they afford concrete and tangible assistance, whereas the habit clinic has no definite authority but has to depend for its cooperation upon the parental instinct and a friendly contact, and its assistance is at times very subtle and intangible.

In the majority of cases the results are good. In some the improvement is quick and very marked—in the mother's eyes a miracle. In others the progress is slow and the condition complicated and not fully appreciated by the mother, and she either takes the attitude that there is no use in coming to the clinic as the child is not improving, or else she feels that the problem is too unimportant to bother with. In either case there must be frequent calls in order to educate the mother and insure the proper following out of the treatment. Sooner or later these cases show the effect of the work done upon them, and the mothers express their gratitude. It is in these cases that the social work is most important, as the results depend upon the careful, persistent, inoffensive work which means not merely a series of calls but a program of education.

So much for the education of the parents. Besides the agencies referring the cases and the families concerned, the general public

must be made to understand what the difficulties of children are and how they can be handled. It is the duty of the social worker to disseminate whatever knowledge she has of the above problems and how they can be met, through all the contacts she makes—and they are many and varied—with the relatives, friends, nurses, dietitians, teachers, and social workers.

The third important aspect of the work is research. The worker is careful to collect accurate material and present it in a convenient, workable form, filing the social data with the medical and psychiatric reports. All the clinical cases are to be visited every six months for five years, so that the development of the case may be studied, as one can not be sure that there will not be regressions. In addition to this group there are 100 cases taken at random, consisting of children who have been discharged from the baby-hygiene conferences and are entering school. A psychological test has been given each of these children and a complete environment study is to be made. These children also are to be visited every six months for five years. At the end of that time it is hoped that some conclusions can be drawn concerning the relations between the innate mental capacity of the child, the home conditions, and school progress.

In conclusion, the social worker's duties may be summarized as follows: To do the routine work of the clinics; to develop a special technique in dealing with children's cases, involving delicate and subtle contacts with the parents; to help the agencies, families concerned, and the general public to understand the methods of handling the problems of children; and lastly, to analyze and study the cases and prepare material for research.

THE CHILD.

Almost every discussion of the child carries with it a long dissertation on heredity, which frequently leaves one in a state of increased perplexity if the author has entertained a nonpartisan point of view or with some very dogmatic ideas, pro or con, depending upon the authority perused. For example, John Stuart Mill stated, "Of all the vulgar modes of escaping from the consideration of the effects of social and moral influences on the human mind, the most vulgar is that of attributing diversities of conduct and character to inherent natural differences"; and Frederick Adams, about 10 years ago, concluded that "experimentally and statistically, there is not a grain of proof that ordinary environment can alter the salient mental and moral traits in any measurable degree from what they were predetermined to be through innate influences." Kirkpatrick² expresses the consensus of opinion of the physicians dealing with the practical problems which are concerned with the subject of heredity, when he states—

From the individual standpoint, heredity should neither be ignored as of no importance nor yielded to as inevitably fixing one's destiny. Instinctive and hereditary tendencies are the roots from which the physical, mental, and moral life develops. Some individuals develop more readily and to a greater degree than others. All are of the same human characteristics, but each may make the most of his environment. Some can not go as far as others in certain

² Kirkpatrick, Edwin A.: *Fundamentals of Child Study*, p. 29. The Macmillan Co., New York, 1917.

directions nor as easily, but no one has exhausted his possibilities of development. The practical problem is to expend our efforts upon the useful characteristics which we possess in the greatest degree.

It seems only reasonable at this time when so much disparity exists in the opinions of various authors on heredity that a conservative point of view on the subject, such as that presented by Kirkpatrick, should be tentatively accepted. Such a hypothesis makes it possible to get away from that pessimistic attitude to which the fatalist clings with undying tenacity. Doing this is not seeking the fool's paradise and becoming oblivious to the biological facts of life as they exist. Whatever may be the relation between the germ-plasm and the color of eyes or the size of feet, or whatever actual research may determine in regard to defective germ-plasm—how it affects the number, size, and distribution of brain cells, evidently resulting in variations in inherent mental equipment and setting definite limitations on brain development—no one, as yet, is ready to say that personality and all its component parts are not molded and colored by social heritage to a great degree. After all is said and done, social maladjustments and economic deficiency are more frequently due to emotional instability than to intellectual defects. More is to be gained from concentrating efforts on the study of environment and its effects on the development of personality than can be hoped for by accepting the hopeless, fatalistic theory of heredity.

In the attempt to understand the child it must not be forgotten that just as he has ears, eyes, a brain, and a heart, the child also has instincts and emotions. He has an inherent hunger for self-expression that is constantly infringing upon a code of laws and customs of which he has, as yet, no understanding. We must keep in mind the fact that the child has plans, hopes, and ambitions; he has doubts, fears, and misgivings; he has joys and sorrows, some very slight and fanciful, others very deep and real. This emotional life is thwarted and gratified in much the same way at the age of 3 that it is going to be at 30. With all these instinctive and emotional drives, which have much in common with the adult, there is necessarily lacking that stabilizing factor called experience, which can come only with years. The child is confronted with many situations for the first time in his life, to which there is a definite, unpleasant, emotional tone. These situations, when repeated in the light of the past experience, will be associated with a pleasant feeling tone. For example, many of the primary experiences of children with animals are accompanied by fear. Jealousy is often aroused when the child first appreciates that the mother is giving some of her attention to other members of the family. Anger is aroused repeatedly until the child appreciates the reason for the acts which arouse these emotions, and then quite suddenly and unexpectedly the emotional reaction changes. The child, therefore, must be considered as an individual with all the equipment necessary for registering joy and sorrow, pleasure and pain, but he is not well equipped by experience for evaluating properly the details of the situation so that the quantity and quality of the emotion will be adequately expressed. Regrettable as it may be, adults all too frequently stimulate for their own amusement some of the most undesirable emotional reactions in the child, leaving scars on the personality of the child for all time.

Childhood is not only the opportune time but the only time to inaugurate a program of mental health. Seeds of pugnacity, selfishness, and feelings of inferiority are sowed early. They may not bear fruit until later—perhaps not at all; but if one expects to reap the blessings of an adequate, well-rounded, self-sufficient type of personality in an offspring, the seeds must be planted during the earliest years and carefully nurtured. The mental life of the child is characterized by his tendency to imitate, his suggestibility, his love of approbation, and his marked placidity. These qualities, in association with his lack of experience, training, and education, render an interpretation of his mental activity less difficult than in later years; and all these factors may be utilized to great advantage in our efforts to stimulate, inhibit, or alter his reactions toward the problems of everyday life. In the effort to understand human behavior the thoughts and feelings of the child must be taken into account. His daydreams become matters of importance. More intimate knowledge of his mental life is needed. It is necessary to take time to find out why he is queer, quiet, or reserved, why he is worried or sad. The situation demands the utmost ingenuity and patience in assisting the child to solve his own problems and at the same time appreciation of the fact that it would be of little value to solve them for him.

THE PARENT.

Notwithstanding the fact that the great majority of parents have been endowed with what may be termed the parental instinct and a sufficient intellect to rear their offspring for ages past in such a way as to fit them for the society in which they were born without the assistance of the various social organizations which have sprung up within the last century, it must be recognized that there are no small number of inadequate personalities—the so-called misfits in life—whose failure may be attributed directly to their social heritage.

In any study of environment it is absolutely essential to have the fullest details possible regarding the personality of the individuals with whom the child comes into intimate contact. The home must be considered the workshop in which the personality of the child is being developed; and the personalities of the parents will make up, to a very large extent, the mental atmosphere in which the child has to live. This mental atmosphere may easily become contaminated and quite as dangerous to the mental life of the child as scarlet fever or diphtheria would be to his physical well-being. Faulty habits are invariably due to the imitation of bad examples. Yet one is quite safe in saying that the imitation of the bad example is frequently not so dangerous to the child's mental life as the way in which the indiscretion is treated by the parent.

Parents who contribute largely to the inadequate development of the personality of their children may be divided into well-defined groups. There is the mother, worn and wearied by her routine household cares, who tries to supplement the family budget by putting in a few hours scrubbing floors when she should be in bed and who has little energy, either physical or mental, left for her children's welfare. Contrast her with the work-avoiding, duty-shirking, pleasure-loving mother, who feels that her duty is ended

at the birth of the child and turns over her responsibilities to a nurse-maid. Again, there is the mother with most excellent intentions, whose interest is apt to defeat its very purpose. Usually she is oversolicitous and caters to every whim and desire of the child. All too frequently she is emotionally unstable, and the child soon finds out that there are no definite rules and regulations about discipline. What is condoned to-day is punished to-morrow; and in spite of ability to adjust rapidly, he finds it difficult or impossible to follow a consistent line of conduct. There is no situation more pathetic for both mother and child than that which confronts the mentally defective mother who is doing the best she can with what she has and yet is failing and recognizing her own failures.

So far only the mother has been considered, but it must not be forgotten that at the end of the day the father is introduced into the family circle; and he may spread peace and harmony where chaos was wont to prevail or he may disrupt and render chaotic that which was peaceful. The stern, righteous, rigid father, who dominates the household by fear, is, from a mental point of view, most undesirable in the environment. Yet the child is not to be envied who has a quick-tempered impulsive parent who deals out a word and a blow, the blow coming first. Lucky is the child who does not have his discipline handed out by some emotionally unstable parent, often in an extremely erratic manner.

Needless to say, the foregoing types fail to furnish the child with that companionship which he needs most. Cheerfulness, affection, kindly consideration, frankness, and honesty in answering questions with the idea of developing freedom in speech and action uninhibited by fear of punishment or silent contempt, manners and speech that are not forbidding—all these tend to play a part in the development of the personality of the child that can not be overestimated.

The following case is a good example of a mother bringing a child to the clinic when the child should have brought the mother.

CASE No. 1.—A woman about 40 years of age brought her little girl, 7 years old, to the clinic for examination, stating that she acted like a child 4 years old. The mother was unable to give any concrete examples of the child's immature acts. As far as could be discovered the child had no bad habits. She sleeps and eats well and is frank and honest. She would like to be affectionate if her mother would permit her to be. She shows no cruel tendencies, and about the worst the mother could say was "She takes up with any child she can find, regardless of creed, color, or nationality. I will not stand that." The mother stated that she would not permit her child to associate with the Catholic children in the neighborhood and that the Protestant children were not good enough.

The patient appeared to be a bright, keen, alert little girl, who answered all questions quickly and accurately. She manifested an interest in the examination and her surroundings. In the psychological test she graded high, having an intelligence quotient of 98. As far as the history from the mother and the examination of the child were concerned there seemed to be but little evidence to indicate that the child is either abnormal or unusual.

The mother was interviewed again, and it was ascertained that this child was not wanted, that the mother and father had been quite happy until her birth, and that she was looked upon as a stumbling block in their happiness and economic success. The father's attitude toward the child was one of indifference. He rarely gave her any attention at all. The mother states that she is not fond of her because the child is hateful and always makes the mother regret being kind to her. When the mother and father are together they both ignore the child, and she is sent off by herself and not permitted to play with other children.

Further investigation of the case by the social-service department of the clinic reveals the following facts: The mother is looked upon in the neighbor-

hood as being "different." Although she is very affectionate toward her husband, the neighbors state that it is not infrequent to hear her tell the child that she hates her. It was later ascertained that until a year before the patient was born the mother was looked upon as a very desirable neighbor. About that time she went away to live with a man who had been a boarder in the house and returned to her husband only after the authorities made complaints. Shortly after her return the patient was born. Since that time the whole situation had changed.

One of the most pernicious influences to which a child is subjected is that of persistently interfering members of the family group. Grandparents are perhaps the worst offenders along this line, although other relatives may complicate the problem of bringing up children quite as much, if they are so inclined. This is particularly true, of course, if these individuals are living in the same household, but not infrequently their influence is felt even when they reside at some distance. Too much stress can not be laid on the necessity of having the disciplining of the child invested entirely in the hands of the parents. Nothing does more to lessen the responsibility of parental authority than to have some line of action which the parent has decided to carry out questioned by others in the presence of the child.

Another situation frequently arising with reference to the problem of discipline is that brought about by the divided household; that is, the inability of the parents to agree upon any plan of action with regard to training the child, each one forming spontaneous judgments as the occasion arises and entirely on an emotional basis. Much of the difficulty arising because of a divided opinion regarding some particular act of the child might be avoided if parents themselves could get some clearer idea of the relative importance of so-called misconduct in children, but all too frequently it happens that the same punishment is meted out for some quite accidental offense of the child, such as breaking a window with a baseball, as would be given for some obviously voluntary malicious act involving cruelty.

With the child who has the misfortune to have a physically handicapped parent—especially a mother—it is very important, on the one hand, that too much stress should not be laid upon her incapacities, and, on the other, that the child shall appreciate at the earliest possible age the burden which the parent is carrying and the consideration to which she is entitled. Not infrequently one sees problems of delinquency arising under these conditions because the parents have been physically unable to "make the children mind," but much can be done through appealing to the sympathies of the child, especially when the object of his sympathy is ever before him.

All too often adults are prone to utilize what appears to be the most potent means of obtaining obedience from the child, and as fear is one of the most primitive and easily stimulated emotions it is used more freely perhaps than any other.

Cheating the child by making promises which the parents know they can not keep or which they have no intention of making an effort to carry out is perhaps the origin of the absolute disregard for truth and the exaggerated suspicion seen in many children at an early age.

"The doctor has a lot of nice things in his bag, which he will give you if you stop crying," one mother said recently. She followed this

up with the statement that "Mother is going to buy you heaps of pretty things as soon as the doctor is through," and made other promises which obviously she had no intention of carrying out.

Some time ago a little girl who was being treated for persistent thumb sucking and refusal of food was making a routine visit to the clinic, and the psychiatrist was told that during the last week the mother had given her a nickel and sent her to one of the settlement workers to go to the dentist's. The child did not report to the worker and spent the nickel for candy. It is interesting to note, however, that the preceding week the mother had told the little girl that she was going for an automobile ride, and the outing had terminated in a very unpleasant session in the dentist's chair. However one may interpret the relationship between the two incidents, it is doubtful whether the indignation of the mother at being deceived was greater than that of the child.

In other cases grown-ups try to frighten a child into obedience. "Don't touch the telephone," another remarks, "it will bite you." "The policeman will get you if you are not good." "The doctor will put the stick down your throat if you don't answer his questions." Fortunately for the peace of the child's mind, he finds that such promises and threats are not to be taken seriously, but unfortunately he is unable to distinguish between the persons whom he can trust and believe and those whose advice and warnings are simply idle prattle. Consequently he is likely to develop an absolute disregard and disrespect for the opinions of others and later in his life will be a person insensitive to praise or blame.

Another group of cases in which fear plays a very important part during the early part of the individual's life, frequently is carried into late adolescence, and sometimes is never completely eradicated is that in which the fears are stimulated in relation to some instinctive aspect of the individual's life. Frequently sex problems are created in this way by the parents. One little girl who was battling the problem of masturbation happened to live near one of the State hospitals for the insane, and it was firmly impressed upon her that if she continued the habit that was where she would eventually end. She was driven around the institution in order that the threat might be more firmly implanted upon her mind. The child was told that soon everybody would know what she was doing—that they could tell by her expression and the way she acted. Other children are threatened with operations under the same conditions. It is not infrequent to find parents mutilating the fingers of young children, either by burning them or pricking them, for this habit. It is hardly necessary to comment upon how acutely sensitized the young, immature mind becomes to the habit of sex when such drastic measures are taken by perhaps interested but injudicious parents. So many of the inadequate personalities that we see in adult life undoubtedly find their origin in the feelings of inferiority which are stimulated during childhood. Apparently everything is done to make these children feel that they are different, and it is not surprising that they become shy, timid, and self-centered, finding themselves in association with others who are quite intolerable to them, and that they consequently seek solitude and build up in fantasy a dream world in which they can reside unmolested.

FEEDING.

There is no problem which causes the parents more concern than that of the child who has difficulty in taking and digesting his food. The more common feeding problems are refusal of food, sucking of food after taking it into the mouth, regurgitation, and vomiting. The fact that parents develop such a marked anxiety with reference to these difficulties invariably makes them oversolicitous, and this, in itself, is the most important factor in perpetuating the difficulty. No other part of the entire body is so directly affected by emotion as the gastrointestinal tract. Physiological research has established the fact that emotions of various sorts, such as fear, anger, and excitement, influence directly the flow of secretions which have to do with the digestion of food, so it is not at all surprising to find that an organism so highly developed, yet so unstable, as that of the nervous system of the child may reveal very clearly the relation between psychogenic and physiological processes. Notwithstanding the fact that it is usually not difficult to pick out those children whose loss of appetite and inability to digest and assimilate food are due to psychogenic rather than physiological causes, it is essential to have these cases clearly differentiated by careful physical examinations. A large proportion of the children who come to the clinic because of difficulty in feeding are poorly nourished, anemic individuals. On the other hand, their physical condition is frequently such that one sees little cause for anxiety until the history of the case is presented. In such cases it is found that although the child's intake of food is fairly high, it is of such a quality and taken under such emotional stress that it fails to serve the child's needs. The mother states, perhaps, that the child absolutely refuses to take food unless she sits down by his side and actually carries out all the necessary motor processes to get the food from the plate to the child's mouth, and even then she may have to tease, coax, threaten, and sometimes punish the child in order to make him swallow the food. After satisfying herself that the proper number of calories or ounces of food have been taken into the stomach of the child the mother is naturally quite dismayed to have the food vomited before the child leaves the table. It is not, however, surprising when one considers the effects of emotion upon the process of digestion that a stomach so inadequately prepared to receive food should reject it.

Then there is the child that becomes antagonistic toward certain types of food—soups or cereals or vegetables of a special color. The antagonism toward some particular article of food which persists over a long period of time may have been aroused by the injudicious methods utilized the first time the food was presented to the child. There is no doubt that a great mistake is made in the effort to make the child eat some especial article of food which the parent believes is absolutely essential to the child's well-being, when the parent is dominated by the idea that if he is not successful upon the first attempt the battle is lost. Under such conditions there is apt to be enacted a very unpleasant emotional scene which lingers in the mind of the child and is recalled the next time the food is presented. It therefore seems wise to guard against making an event

of introducing a new article of diet into the child's menu. It should be presented without comment and without obvious doubt in the mind of the parent or nurse as to its being eaten; but if, for some reason known or unknown, it is not taken at that particular meal, an unpleasant scene should be avoided and it should be presented at a later date without comment or show of indecision.

It must always be borne in mind that it takes a certain amount of manual dexterity for children to feed themselves, and it is invariably easier to feed the child than it is to teach him to feed himself. It is one of the first more complex acts which he is called upon to do more or less independently, and it is not surprising that he accepts this new responsibility with a certain amount of reluctance. Usually, however, with success there comes satisfaction, which stimulates the child to further efforts toward accomplishment.

It is of paramount importance to avoid discussion of his feeding habits before the child. Such a practice tends to fix the event in the mind of the child and make him cognizant of the fact that he is the center of attraction during the meal hour. Many children find that an antagonistic attitude, not only toward feeding but toward sleeping, playing, and general obedience, is one way of attracting the attention which they so desire.

After eliminating the physiological causes of loss of appetite and malnutrition it invariably works out well to serve the child a small quantity of well-prepared food and give a sufficient period of time in which to eat it slowly. If not eaten the food is removed at the end of that period without any ceremony whatsoever, and this method is repeated for a series of meals. Under the foregoing conditions much of the drama in which the child delights is removed, and much of the unpleasant emotional reaction produced by stimulating an antagonistic attitude in the youngster is avoided.

Some of the cases outlining the difficulties associated with feeding will give more detail regarding the importance of not directing the child's attention nor arousing his antagonistic attitude toward his food and the necessity of allaying the doubts and fears in the minds of parents so they may at least appear less concerned.

CASE No. 2.—A. A., aged 3, first came to the clinic November 8, 1922.

The history is briefly as follows: Birth was difficult, necessitating the use of instruments. He weighed 10 pounds, was breast fed, and developed into quite a normal boy. There have been none of the ordinary diseases of children up to the present time, but at the age of 2 he was treated with radium for a persistent thymus, and at present he has enlarged adenoids and tonsils.

The child has never slept restfully but tosses and twists about in his crib, often talking and crying out. He is extremely finicky about food and has marked likes and dislikes. Sometimes he gets and eats seven apples a day, does not care for milk, refuses vegetables, but is fond of meat, which is given to him periodically. The child never wants the food set before him at mealtime. He is inclined to be shy and diffident, especially with strangers and adults, although he plays with other children on the street—usually with girls about two or three years older than he. He also plays with boys when opportunity arises. He is fond of throwing a ball, wants to be doing just what others are doing in games, and is very active. He is very fond of his mother and is often called "mother's boy"; is chummy with his father and most considerate toward his sister, who is two years younger than he. He is very selfish and hates to divide, and when he does share with others he always keeps the "lion's share." His mother states that he is very stubborn

and will not do as he is told—he is more likely to do the opposite. His mother punishes him at times, but her strongest hold on him, she thinks, is the threat to leave him.

At the clinic the child was keen and responsive; answered all questions quickly and in detail; cooperated well; and was interested in tests. He enjoyed being the center of attention and was very pleasant and kindly about it all. He paid much attention to his mother and little sister. His intelligence quotient was 130, or one year ahead of his chronological age.

There is nothing regarding the home situation that seems important just at this moment. Both parents are fairly intelligent, very friendly, and cooperative. The father, however, drinks periodically but does not come home drunk or dissipate to any extent as far as the family knows. This situation may be of some importance later on in its effect on the child. The parents are working together for the good of their children. The father's salary is adequate. The home furnishings are average; they live in a four-room apartment in good condition and well kept.

Summary.—It appears that this child, 3 years and 4 months of age, is of rather superior intellectual endowment. His environment presents nothing outstanding in the way of a social problem at the present time. The principal anxiety of the parents is a feeding problem, the child being poorly nourished and underweight, extremely finicky about food, showing strong likes and dislikes with various articles of food. The child is stubborn, very negativistic, rebels at authority whenever thwarted, and reacts by whining.

The first and most important step in the treatment of this case appeared to be the regulation of the sleeping hours, it being perfectly obvious that a child of 3 years should retire before 10 p. m. The mother was instructed that before any improvement could be expected the child must be trained to go to bed at 7 o'clock and have at least 12 hours of sleep. She was warned of the difficulty which would arise at first in trying to put this new program into operation. It was carefully explained how it would be much easier to institute such a program at this time than it would be two or three years later, and her cooperation was assured. The next step necessitated rather a long, detailed explanation to the mother of the means and methods which children use at an early age to obtain their own way. It was pointed out that it was quite useless to get the child established on a health diet so long as he was given apples and candy when he refused to take milk and vegetables; that just so long as stubbornness served as a means of obtaining what he desired, just so long would he utilize that method; and that it was extremely important for the child at this age to learn that whining and rebelling would not serve as a method to gain his own end. A dietary was carefully prescribed, and the mother was instructed to place before the child at each meal only moderate portions of food. She agreed that the food should be left before the child for a period sufficiently long to permit him to eat slowly, yet not long enough to permit him to play with it, and that then it was to be removed and he should receive nothing else between meals excepting the extra milk which was prescribed in the dietary on account of his being underweight. The parents were in no way to concern themselves with what the child was eating. A careful record of the success or failure of the treatment was to be kept by the chart system. The entire plan was explained to the child as simply and concisely as possible.

The results in this case alternated between success and failure from November until May. Cooperation on the part of the mother during the first part of the treatment was not what had been hoped, but each time that the case returned to the clinic, regardless of whether success or failure had been reported, renewed efforts were made to have the mother carry out in detail the plan outlined.

At the end of six months the following report was made: "The child is doing remarkably well, eats all vegetables including carrots, spinach, and string beans, still has a strong dislike for milk but takes one glass per day." A month later the note states, "Patient continues to take his food without difficulty; has shown marked physical improvement; takes great interest in presenting his chart, which shows a perfect record for the last two weeks; is much less negativistic; is no longer shy, and takes great pride in telling the physician of his improvement."

Comment.—This case is particularly interesting because success in treatment came only after a period of five months, during which time the outlook seemed rather discouraging. It emphasizes the importance of persistent and

continued education of the parents in a certain group of cases where cooperation is not of the best and where suggestion is not accepted willingly by the child. The results, however, justified the efforts, as with the establishment of proper sleeping hours and feeding habits the child became more obedient and less selfish and has lost many minor neurotic manifestations, such as nail biting, whining, and restlessness at night.

CASE NO. 3.—B. B., aged 6 years 9 months, was brought to the clinic by her mother November 17, 1922, because of persistent vomiting and enuresis.

The child's history is as follows: Normal birth; full term. Development retarded; did not walk until over 2 years of age; still talks quite indistinctly; teething delayed. Pneumonia at 2 months; whooping cough at 2 years; influenza, 1920; chicken pox, 1922; subject to coughs and colds.

The child sleeps and eats well and has no history of any undesirable habits with the exception of enuresis both day and night and persistent vomiting after meals, a habit which began about four weeks ago.

The child is shy and will not speak unless spoken to, even at school; frequently hangs her head when spoken to by the teacher and refuses to answer. She is extremely selfish and jealous of the other children. At home she is quarrelsome but gets along without difficulty outside. She seems to have normal interest in and attachment to other members of the family with the exception of the younger sister, Susan, toward whom she is very antagonistic. At the clinic she seemed to be a dull, apathetic child who hung her head and refused to look at the examiner; she was extremely lacking in self-confidence and displayed absolutely no interest in her surroundings. One felt at once that there was a problem of mental deficiency to cope with—a fact borne out by subsequent tests and psychometric examination. Her intelligence quotient was 64, which seems to be a fair indication of her mental equipment.

The home environment is poor. The family live in a very narrow tenement street. They have an apartment of three rooms, which are untidy; dirty clothing is lying about on the floor; the hand towels and dish towels are hung up very much soiled; there is a pail in one corner of the kitchen which is used as a toilet. The mother and the youngest child, aged 2 years, sleep together in a double bed, while the father, the patient, and her sister Susan, sleep in another double bed. They have lived here for five years. Notwithstanding the fact that present conditions are extremely poor, they have shown considerable improvement during the last few years. Previously, they were living in one room, the father was drinking, the mother had no interest in the children whatever, and they were very much in debt. At the present time the father has stopped drinking, the mother is taking more interest in the children, and they are no longer in debt.

The patient was brought to the clinic because of persistent vomiting, which began about four weeks prior to the visit, and for enuresis, which had been almost continuous since birth. No attempt had ever been made to establish a routine that would break up this habit.

It is not difficult to determine how the vomiting had its origin. The mother, because of her pregnancy, had been vomiting for the past few months, frequently in the presence of the child. It did not matter to her whether she utilized the sink in the kitchen, the coal-hod in the livingroom, or one of the open windows in the back. How much of the behavior of the child was imitation and how much was stimulated by the physiological reaction of seeing another vomiting it is difficult to say. However, as soon as the mother was instructed about the necessity of seeking privacy during these vomiting periods, and after it was explained to the child (although mentally deficient) how unnecessary it was to persist in this habit and how foolish it would be for her to continue to take food if she persisted in throwing it up immediately, the problem seemed to be solved, for within two weeks the vomiting ceased completely.

Further investigation showed that Susan, two years younger and of higher intelligence, was also troubled with bed wetting at night. The routine measures were instituted at once for both children. A chart system was put into operation, and rivalry as to which one would bring in the best record was stimulated. The results in both cases were extremely gratifying so far as the enuresis was concerned.

It is quite obvious that the problem of mental defect, jealousy, and pugnacity in these children is more fundamental than the symptoms which we treated and cured. On the other hand, one must consider the environmental situation and appreciate the limitations of training under such conditions.

At the present writing, another youngster has been added to the household, making four children in all, the oldest of whom is just over 7. The mother finds it necessary to go out to work and has taken a job cleaning a theater at night. She leaves the house at 10:30 p. m. and works for eight hours, sleeping most of the day. She well represents the type of mother who is worn and wearied by toil and has but little to contribute to the welfare of the home. She is, however, extremely gratified in having her burdens lightened to the extent they have been. Both children continue to visit the clinic at frequent intervals, the mother feeling that they are more easily disciplined if they have to make a report to the clinic occasionally.

Comment.—The interesting point in this case is that it shows how important imitation is in the mental development of children and also the fact that feeble-minded children do respond well to the simple training methods.

CASE No. 4.—C. C., aged 5½ years. Birth and development quite normal. There is nothing of importance relating to her past physical condition. A careful physical examination at the present time shows nothing worthy of note. Special attention has been paid to the patient's gastrointestinal tract, to test meals, and to X rays for evidence of organic disease.

The patient was brought to the clinic by her aunt, who stated that she would not eat unless fed but held her food in her mouth and persisted in regurgitating it. When left alone at her meals and told to eat she invariably hid the food and told fanciful tales as to what had become of it. On one occasion when told to eat her breakfast, she hid the food on the attic stairs and said she had eaten it. When taken to her father's store and given crackers she secretes them on her person and then throws them away, sometimes hiding them behind barrels in the store but always insisting that she has devoured them. She would play all day, it was stated, without food. There is no difficulty, however, in getting her to eat ice cream and candy.

The child's father and mother both died during an influenza epidemic, when she was 2 years of age. At that time the patient was taken by an aunt and uncle, with whom she has since lived and who are apparently devoted to her and seriously interested in her welfare. At the time of her parents' death she had not learned to feed herself, and the struggle to teach her has persisted ever since. She has formed the habit of not eating unless the aunt sits down and feeds her, which means cutting up the food and conveying the morsels from the plate to her mouth. The child more recently has begun simply to hold the food in her mouth, refusing to swallow it. The aunt reports that breakfast is a daily ordeal, and she feels that the child must be forced to eat before going to school. It is stated that she has gone beyond all limits of the normal hunger period for the ordinary child. Excepting for her capriciousness regarding food, there seem to be no undesirable habits. She sleeps well, is ordinarily obedient, has well-established toilet habits, and no particular defects in her personality make-up.

At the clinic the child did not appear at all undernourished but seemed to be happy and cheerful. Her only comment regarding not eating was as follows: "I dream of a beautiful fairy in yellow who told me that I should not drink milk." After a careful physical examination, the child without any hesitation, however, did drink a glass of milk and eat a half slice of stale bread.

The aunt was instructed that she should not be so solicitous over the child's meals. They should be carefully prepared in small quantities and placed before the child, who should be told that she would have 15 or 20 minutes to eat her food and that then it would be taken away and she would have nothing else until the next meal. It was insisted that these instructions be carried out until she came to the clinic the next week. The problem was also discussed with the child, and an effort was made to impress her with the importance of taking her food at regular intervals and also of eating it without assistance from her aunt. The following week the aunt reported to the clinic that the patient got along well for the first four days after their visit but that since then she "has been carrying on pretty much the same way as she always has." She finds it more difficult to discipline the patient than her own child and clings tenaciously to the idea that she wants to do by the child what the child's mother would have her do. In fact, one sees that she is bending over backward in order to avoid showing any partiality toward her own child.

The family live in a very pleasant, sunny apartment, which is, however, extremely untidy. The table was piled with dirty dishes and half-eaten food,

Food in various pans looked most unattractive and poorly cooked. The floor was unswept, and there were large pans full of unwashed clothes. The aunt's clothing and person were dirty, as were also those of the children. The aunt feels that she is at the end of her resources with regard to the patient and says, "I wouldn't mind to feed her if she would only eat what I feed her." She seems glad, however, to have the child a member of the family, in spite of the difficulties entailed. She feels that the child was spoiled by her parents because they had lost an older child as the result of an accident when the patient was a year old. This undoubtedly made the patient's mother very solicitous and anxious regarding her, and the child was permitted to have her own way. The aunt stated that she felt the child was getting worse rather than better and the habit of holding the food in her mouth was growing upon her.

It seemed impossible in this particular case to organize the routine life of the child in a satisfactory way in the present environment, and an effort was made to remove her from her surroundings until feeding habits could be established. This was accomplished temporarily while the aunt with whom she lived went to the hospital to be confined, and the patient was sent to live with another aunt in one of the near-by suburbs. While living in this household, she did extremely well and had no difficulty whatsoever regarding the feeding problem, but within a few weeks she returned home and shortly afterwards resumed her old methods. Attempts were made to persuade both the aunt and uncle to have the child go to the Home for Little Wanderers for an extended period, but their attachment to the child and inability to appreciate the gravity of the situation made such attempts futile.

ENURESIS.

Before starting to treat enuresis as an undesirable habit it is necessary to eliminate, so far as possible, every organic cause. Conditions affecting the bladder, acute inflammations, and calculi are the most common causes. Local irritations, an adherent prepuce, phimosis, or a narrow meatus should also be considered. Rectal irritations due to worms or fissures are important. Incontinence of urine is frequently associated with a highly concentrated acid urine where the fluid intake has been insufficient, or the enuresis may be brought about by increasing the intake, which naturally increases the amount of fluid to be excreted, the latter cause being much more common than the former. The more general conditions, anemia, malnutrition, and an unstable nervous system (of which enuresis is only a symptom) should receive proper consideration.

After all these organic conditions have been eliminated there still remains a large group of cases which are dependent upon faulty habit formation for their cause and persistence. Even in those cases where definite physical causes have been found and eliminated, the condition may persist from habit.

Enuresis may occur both day and night. It occurs in both sexes with about the same frequency. It may begin in infancy and last until the sixth or seventh year or it may cease at the end of the first year with the condition returning at indefinite periods and lasting from a few days to a few months at a time. Doctors Holt and Howland state,³ "In most cases the condition is purely habit, often associated with other habits which indicate an unstable or highly susceptible nervous system." It is with this group of cases that the habit clinics have been concerned.

There are a few generalizations that may be made about every case. There should be established a régime which eliminates, so far as

³ Holt, L. Emmett, M. D., and Howland, John, M. D.: *The Diseases of Infancy and Childhood*, p. 665. D. Appleton & Co., New York, 1919.

possible, any demand for excessive mental strain. The child should have a simple, bland diet and definite hours of sleep. Routine measures should be instituted to avoid constipation and to stimulate free elimination through other sources than the kidneys. One of the first and most important steps in the treatment of enuresis is to interest the child in making an effort to overcome the habit. This is rarely brought about through punishment but frequently by appealing to the child's love of approbation. The chart system has been utilized with gratifying success in cases of enuresis. Not only does it keep a definite record of the child's achievement during the interval that he is away from the clinic, but in a way it serves as a motive for the effort needed to overcome the habit. The child keeps his own chart, makes a mark for each day and night of success, and over each mark is placed a star. Suggestion, just as the child is going to sleep at night, has worked well in a certain group of cases. The mother sits down by the bedside of the child and just as he is about to fall asleep she has him repeat over and over again, "I am not going to wet the bed." This suggestive treatment is almost identical with hypnotism, which has been used successfully in many adult cases and lends itself quite easily to home treatment.

CASE NO. 5.—D. D., aged 5 years 2 months. First visit to the clinic, February 27, 1923. The patient was born at full term, a 7½-pound baby; breast fed; development normal.

He goes to bed at 6 p. m.; sleeps alone; is not restless except on rare occasions, when he talks during sleep. He is not finicky about food; has a good appetite and no history of constipation or indigestion.

His mother states that she had no trouble with patient until he was 2 years of age. At that time he was very ill of pneumonia, bronchitis, and influenza. Following this illness he would soil himself and wet his clothes and his bed. This condition persisted for two years, but for the last year and a half he has been troubled with enuresis only at night. This occurs about five nights out of seven. The mother states that she has spanked him, rubbed his nose in the urine, deprived him of things, and at the present time she refuses to give him clean pajamas over long periods of time, trying to impress him with the fact that he must learn not to wet his bed.

The child is generous and friendly, likes other people, plays with other children, is not jealous, is inclined to be obstinate, and can not be driven but can be easily disciplined if coaxed. The child has no particular fears and enjoys playing outdoors with other children, but on the other hand, spends much of his time with his little sister playing dolls.

Psychological examination gave an intelligence quotient of 92. He was fairly cooperative, inclined to be boastful, all the time saying, "I can do this; I can draw that." He is particularly interested in drawing. In fact it was difficult to hold his attention on account of his interest in making pictures. He is attending kindergarten and enjoys going to school more than he does staying at home.

The home environment is quite satisfactory, the family occupying a small house consisting of five rooms. The home is clean, tidy, and attractive, and the children each have separate rooms. The mother is interested and ambitious for the children, looking forward to getting a larger house and a yard for the children to play in where they can be away from the dangers of the automobiles. She is, however, of quite a neurotic make-up, having had two nervous breakdowns. The father is in a successful business with his brother, earning an adequate salary. The two children are both in good health and enjoy each other's company. The mother is in fairly good health at the present time.

Summary.—Child, 5½ years of age, with an average intellectual equipment, coming from a good home, troubled with enuresis five nights out of seven, with no other undesirable habits. The treatment, to date, has consisted of cruel humiliation and severe punishment.

The fact that the patient has been treated at numerous clinics leads the mother to believe that the case is hopeless. She claims to have carried out

all the directions given her by the physicians, but in spite of this the enuresis continues.

The boy, as seen at the clinic, is attractive and bright, interested in his environment, and anxious to demonstrate his ability in printing and drawing; discusses his problem openly and frankly without any apparent embarrassment, and expresses a willingness to cooperate. Physical examination and laboratory examination of urine were both negative.

The routine treatment for enuresis was outlined as follows: Patient's diet was to be simple, free from spices and sweets, with only a modest amount of meat; his evening meal was to be served at 5 p. m., after which he should have no fluids; he was to retire at 7 p. m. He was to be taken up and thoroughly awakened and sent to the toilet at 8.30 and again at 10, and then permitted to sleep until morning, when he should be awakened at 6 o'clock. Stress was laid on the fact that the child must be thoroughly awakened and made to realize why he was being aroused at that hour, and the mother was warned to be sure that the child voided when he was taken up. A chart was then brought out and given to the child, and how the record should be kept was carefully explained.

The child responded to his part of the program with much enthusiasm, but the mother evidenced considerable skepticism about the routine outlined for the patient. The patient was returned to the clinic one week later, and at that time it was apparent that she had not carried out the directions, in spite of her statements to the contrary. She had instituted her own treatment with kidney pills. She was, however, prevailed upon to continue the routine outlined for a month and was requested to visit the clinic each week. On April 3 the child was brought to the clinic by the mother, and the note states, "She is much pleased with the change that has taken place in the patient, feeling that the chart brought it about. She is anxious that the younger child, aged 2½ years, be admitted to the clinic as a patient for the same trouble. She states that she did not experiment with a patent medicine as contemplated at the last visit but decided to follow the advice given."

The next visit was made on May 8, when she brought both children. She said that the bed wetting had completely ceased and that she had been relieved of a great burden.

Comment.—The only comments that need be made on the above case are in reference to the tactfulness that is necessary in getting cooperation from the parents and in making them feel that, although they have tried various remedies at different times, perhaps they have never put any plan into operation which took into consideration all the aspects of the individual case.

This case of enuresis was uncomplicated by any other nervous symptoms or undesirable habits, and it is worthy of note that the enthusiasm which the child showed in keeping the chart was, in itself, favorable from a prognostic point of view.

CASE No. 6.—E. E., a girl aged 3 years 9 months, was first seen at the clinic June 22, 1922. The patient was born full term; birth and development normal; breast fed until 11 months.

Patient is in bed from 7.30 p. m. to 6 a. m. Formerly, she would awaken in the night several times but until recently has been sleeping well. Beginning about a month ago, however, she has waked up frightened and crying out, talking about soldiers. She has always been finicky about food. She would not take milk until she started in at the nursery school, but she has since developed a liking for milk and eats everything except meat. She does not eat between meals.

Patient is very shy and says nothing in the presence of strangers but clings to her mother. Although the child is very quiet, her mother states that she is capable of entertaining herself. When younger, she had a severe temper and frequently went into tantrums. She is extremely jealous of her younger brother. This jealousy was carried so far that when her mother first began to nurse him, the patient would not lose an opportunity of slapping or otherwise bothering him. She does not care to play with other children, is self-centered and retiring. She is obedient and rarely has to be disciplined. Her play life is occupied largely with her dolls, occasionally with her brother, and rarely with other children.

The patient has an intelligence quotient of 84. She attends kindergarten, where she is getting on fairly well.

The home consists of a five-room tenement on the second floor of a three-story brick building. The family has lived there for eight years. It is clean

and, although in poor condition, is well furnished. The patient has a room to herself. Patient is more attached to her father than to her mother and lacks a normal interest in her brother.

The problem as presented by the mother is that of enuresis, which occurs both day and night. This condition has persisted since birth. There has been difficulty in sleeping for a long time past. The child is put to bed at 7.30 p. m. and usually goes to sleep within half an hour. Then she wakes up at 1 or 2 a. m. and then every hour thereafter until 7 o'clock, when she insists on getting up. This wakefulness, accompanied by crying, has become a very disturbing factor in the household. For the last three weeks the child has developed an unusual fear of soldiers and upon waking, cries out in fear, saying: "Don't let the soldiers get me!" The story is that on June 5 she was taken to the Common by her mother and saw some soldiers drilling. This for some unknown reason alarmed her, and since that time she has talked constantly about soldiers and says they are going to take her away. When she wakes at night she cries out to her mother, "Close the door, the soldiers are coming!" She refuses to go into any room alone since this event and wants her mother constantly by her side. She has become much afraid of the dark.

At her first visit to the clinic she was extremely shy and would have nothing whatever to do with the examiner and spoke only to her mother in whispers. She resented any attempt on the part of the doctor to become friendly and seemed unusually timid. She was unable to make satisfactory contact at this first visit.

Routine measures for the enuresis were instituted as described in the preceding case, except that the child was permitted to go to bed at the usual hour of 7.30, awakened at 10, and permitted to sleep until morning. The mother was instructed to take the child to the Common each day when the soldiers were drilling and allow her to make such advances as her fear would permit, being constantly assured and instructed as intelligently as her years would allow all about soldiers.

At the end of the month the mother reported that the child had shown considerable improvement and had not wet the bed for two weeks, had slept better, and was no longer afraid of soldiers. The fact that the mother had taken her to the Common every day had seemed to dissipate her fears. The child was more friendly toward the doctor but still shy and bashful.

Improvement continued during the summer months, and in September the child entered kindergarten. The teacher reports that she is now getting along well and shows normal interest and adapts herself to the school work. She enjoys the association with other children, is quite unselfish, well-mannered, and obedient. The mother reports that the patient is getting along splendidly, no longer wets the bed, and has no difficulty about her eating. She no longer entertains any fears which disturb her either day or night.

Comment.—It is interesting to note in this case that this little girl, since June, 1922, has shown such marked ability to adapt herself in a satisfactory way to both home and school conditions. She is no longer wholly dependent on her mother and has become interested and affectionate toward her little brother. She is sleeping well, her appetite is good, there is no difficulty with enuresis, and she is no longer disturbed by fears and terrifying dreams.

Although it was impossible in this particular case to determine the underlying cause of the terrifying wakeful periods, it is of interest to note that many favorable changes have taken place subsequent to, if not simultaneous with, the treatment of the enuresis. This happens so frequently in the treatment of this disorder that it leads one to believe that the feeling of inferiority and shame that is associated with enuresis in so many cases frequently colors the entire mental life of the patient. It is of practical importance in the treatment of mental problems in children where enuresis happens to be one of the symptoms (inasmuch as enuresis is one of the most trying problems to the parent, although one of the most easily curable) to institute treatment for the enuresis at the earliest possible date.

PROBLEMS CONCERNING SEX LIFE.

Mothers of problem children not infrequently say that the habit of masturbation began at such an early date in the life of the child that they are unable to tell just when it did start. Recently the

mother of a year-old child said that ever since birth "he has handled himself." These statements bear witness to the fact that the child is capable of being sexually excited and in many cases becomes aware that pleasurable sensations may be aroused by manipulating the genitals and other erogenous zones. This awareness is usually brought about by some external stimuli such as may take place in giving the child a bath or the various irritations arising from uncleanness, or, quite accidentally, by the rather minute investigation the child makes of his own body; and all too frequently by older children, who through curiosity about sex, make investigation of smaller children. In certain cases sexual precocity has been deliberately stimulated by irresponsible nursemaids.

It is not desired to convey the impression that masturbation in the great majority of children begins at any such early date. When it does begin in these immature years it invariably lasts but a short time, recurring again between the ages of 10 and 14. During this period it is so common that Dr. William A. White states⁴ that a transitory period of masturbation about the age of puberty is probably quite normal.

The masturbatory act is usually carried on by irritating the external genitals with the hand, but only recently I saw a little girl, just over 2 years of age, who was using a small stick to irritate the clitoris. The act is often complicated by other manipulations which apparently add to the pleasure. Thumb-sucking, rectal irritation, and rubbing the navel are most common manifestations, and any one of these acts may be performed alone to the satisfaction of the child.

Visits to the toilet are frequently events of great interest to children and it is not infrequent to find that it is only at these times that masturbation occurs. Not only are their own visits to the toilet but those of the adult members of the household of interest. One little girl was brought to the clinic on account of her interest in seeing people nude. She was accustomed to secrete herself behind the bed or in the closet or peep through the keyhole and put many other ingenious schemes into operation to see any of the adult members of the family nude.

Other children are unduly sensitive about being in the presence of any member of the family while disrobing and at a very early age are what we commonly term "prudish" regarding the problem of sex.

Most of these youngsters, from a therapeutic point of view, fall into two groups: (1) Those who cling very tenaciously to these pleasures and in fact all the pleasures of their lives, and (2) the group which gives them up with little reluctance. Members of the latter group need little or nothing more than to have their energizing forces sublimated along some more desirable path, and little stress need be laid on the undesirable habit itself but rather upon the development of some new interest. The treatment must be outlined to cover not a few days or a week, but rather a period of several weeks. The parents' fears and anxieties over the outcome of the

⁴ White, William A., M. D.: *The Mental Hygiene of Childhood*, p. 82. Little, Brown & Co., Boston, 1919.

habit must be allayed so that they can carry out the treatment without undue emotion. All that is usually required in such cases is attracting the child's attention when he is in the act of performing the undesirable habit, with a picture or a game, or by making an effort to interest him in what the parent is doing at the moment or utilizing other methods which require ingenuity, such as directing the child's attention to some situation, even though it be only of passing interest but sufficiently unique to hold his attention for the moment. The habit, of itself, gradually subsides. These cases are never of the secretive type that masturbates only in seclusion, for in these early years they have not reached the stage when they appreciate the asocial quality of the act, and, as said before, parents may be assured that no undue anxiety regarding these cases is justified if the child is directed with intelligence.

The cases which present the most difficult problem for treatment are those of children who turn to masturbation only when they are in unhappy or despondent moods. They find in this habit a source of comfort and a comfort which is always at hand. Children turn to thumb sucking, especially at night as a means of inducing sleep, just as many adults indulge in masturbation, not because there is any particular sex urge at the time but because they state that there is a general indescribable feeling of unrest, both physical and mental, which can be subdued if sex feeling sufficiently strong can be stimulated. And even in these adolescent and adult cases the act of masturbation is not carried out to its completion.

The most practical method of treatment is as follows:

- (1) Careful physical examination to determine if there are any definite sources of irritation.

- (2) Absolute cleanliness.

- (3) Most intimate knowledge of those with whom the child is making the most intimate contacts.

- (4) Knowing the child well enough to be able to understand his moods fairly well and appreciating the fact that masturbation is frequently sought as a retreat from unhappiness.

- (5) Allaying the fears and anxiety of the parents and making them appreciate that the dangers to the physical and mental being of the child are more apt to come from injudicious treatment than from the habit itself.

In any attempt to dispense with an undesirable habit something must be substituted for that which has been taken away. Not only must approval replace disapproval, pleasure replace pain, reward replace punishment, but some very definite tangible way for sublimating energy must be presented to the child and presented in such a way that it can be utilized.

Considerable experience has shown that mechanical appliances which are used for restraining children are of little value unless the child is at an age when he can fully appreciate why the restraint is being used and a state of mind can be developed in which he is quite willing to cooperate instead of resenting the treatment. If restraint is used forcibly the situation resolves itself into an open battle between the child and the parents in which both are doomed to lose; for invariably the child clings to the undesirable habit in spite of these drastic measures.

CASE No. 7.—This case is presented in considerable detail as it brings out several important points regarding the early development of sex interest in children, and it is further complicated by convulsions of an epileptoid character, which was the symptom that brought the patient under observation.

A few months ago F. E., a 9-year-old girl, was brought to the clinic by a worker of one of the societies interested in children, for two definite reasons: (1) Because of convulsions which resembled epilepsy, and (2) because of her precocious sex interest and sex delinquencies, which had begun when the child was between 5 and 6 years of age. The episode that brought the child to the attention of the society mentioned was the finding of an obscene picture by the patient's teacher.

Physical findings were negative, except for a positive tuberculin test and the spells which resembled petit mal attacks. The gynecological examination, which was made on account of the social history, indicated a certain amount of irritation of the genital organs. The child was well developed and well nourished.

Mental findings graded the child one year above her chronological age, which gave her an intelligence quotient of 111 on the Stanford scale. She was much interested and entered eagerly into the spirit of the tests. She graded uniformly, except for particularly good rote memory and in practical judgment, which was below her mental age. She is in the third grade at school and capable of doing work that is above the average. The teacher considers the child very bright, but at times she states that she appears extremely dull and absent-minded.

The parents state that the patient has immoral habits, that she never seeks girl friends but is always in the company of boys, and that she has immoral relations with them. In 1920 the child was found in a cellar with several boys of her age, in what was said to be a compromising position.

No information was obtained regarding the grandparents of the patient, but her father is said to be a fine, self-respecting man, who is making every effort to do all he can for the welfare of his family. The patient's mother died four years ago, was an epileptic, and a very marked hypersexual individual. She died at the Psychopathic Hospital in 1918 from toxic psychosis. The patient's father married a second time, and the stepmother seems to be kindly and affectionate toward the child and interested in her welfare. She, however, receives but little support and encouragement from the three older married sisters in the family in matters of discipline concerning the younger children. She has found the situation impossible, and a separation has resulted, not because of any difficulty with her husband or of inability to meet the ordinary problems concerning her household duties but on account of the conduct of the patient and the lack of support in her effort to change the girl's conduct for the better.

The patient until recently lived at home with her father, stepmother, and brother John, aged 13, who is in the eighth grade at school. He is said to be quiet, but he indulges in petty stealing and has been arrested twice. There are three older married sisters who continually interest themselves in the father's household, much against the wishes of their stepmother and probably to the disadvantage of the home. The father states that none of his children have seemed normal. He has always had difficulty in bringing them up. They were delinquent, misbehaved, and had bad reputations. On the whole there seems to be nothing obvious in the immediate household which would account for the delinquent tendencies of the children.

For the last three years, the child has interested herself in boys, although from her story she has not excluded girls as companions in her erotic indulgences. From the history it is felt that the patient has been more of an influence on the environment than the environment has been upon her. The father states that since the child was 3 years of age she has shown an abnormal interest in sexual things and has been quite aware of her own sex feelings and how to stimulate them. When returning from the moving pictures she appears to remember nothing but the sensuous aspect of the picture, frequently fabricating and interweaving situations. The patient has been found on several occasions in the cellar of an unoccupied house absolutely nude, with three or four boys of her own age. She tells her father of what has happened and evidences no sense of shame in speaking of the active part she has played in these episodes.

In the doctor's office she answered all questions frankly and showed herself an extremely precocious individual, having an intimate knowledge of sex af-

fairs which could have their basis only in personal experience. She made no effort to minimize her part in these unhappy events but expressed voluntarily a desire to overcome these hypersexual tendencies. She discussed the entire situation without embarrassment, went into minutest details, discussed her innermost thoughts and her dreams in an interesting and enlightening way. She appreciated the effort that she must make in order to overcome the cravings and desires responsible for her past difficulties. She was also anxious to develop other interests to substitute for her erotic daydreams. At no time did she blame others for her trouble, and she stated that she was extremely anxious to overcome her undesirable habits in order to make it easier for her stepmother, to whom she was apparently very much attached.

This case presents two definite problems for solution: (1) The convulsive tendency and (2) the precocious sex interest and sex delinquencies. Physical findings in the case are essentially negative. Mental findings indicate that the child has more than ordinary intelligence. Her teacher considers her bright. The delinquent behavior may be considered as accidental in origin and as being continued because of hypersexual cravings. Home conditions were not ideal, yet they were not sufficiently different to account entirely for the strain of delinquency found in this family. Associations were not better or worse than those found in many districts. Nothing stands out distinctly either in the mental make-up of the child or in the environmental conditions which can be definitely pointed out as the exciting factor of her present difficulties.

What the effect of such a series of experiences upon the development of character and personality of the child may be, is open to conjecture. The cause or reason for that particular experience in this individual case at such an immature age may well be considered as environmental or accidental. The effect of such an experience will depend upon circumstances and conditions that are as much beyond the control of the child and quite as dependent upon "happenstance" for a healthy solution as the primary experience was dependent upon mere accident.

The fact that this child is of rather high-grade mental equipment and somewhat precocious in her interests other than those of sex, is indeed fortunate, for the unhappy event can be very well assimilated and digested by the child, minimized by the parents, and, perhaps, turned to some good purpose. On the other hand, it may be repressed so completely as to lose its own identity entirely but appear in some quite pathological condition or definite asocial act—as apparently occurred with this patient in her hysterical episodes. Again, the experience may be rather imperfectly repressed, and continually and persistently forcing its way into consciousness, may produce disintegration of the personality, such as is manifested in many of the psychoneuroses of the neurasthenic and anxiety types.

From a physiological point of view it is not difficult to conceive of such experiences as sensitizing the individual to subsequent emotional experiences of a sexual nature, producing a hypersexual individual, which may result in prostitution, homosexuality, or other perversions. Notwithstanding the fact that there may be this tremendous physiological sexual drive, it is not unlikely that such an experience would produce a psychological repugnance to things sexual, the two forces combating each other and resulting in conflicts which torment and incapacitate.

While the child is passing through these experiences she needs all the help and understanding that she can get from those having the case in charge. It is perhaps much easier to wait 20 years and then begin philosophizing about the effect of such an early sexual experience and its relation to the nervous breakdown of an adult, than it is to get a clear, concise picture of just what is taking place when the child is passing through the series of experiences. But there is no comparison between the real value of information gained while the forces are operating and guessing 15 years later what actually happened and how the mental mechanism worked and the effects the experience may have had on the development of the individual.

COMPLICATION OF HABITS.

CASE No. 8.—G. G., aged 3 years 8 months; first seen at the clinic January 18, 1923. The history of this case reveals several undesirable habit reactions, discussed in different cases elsewhere.

The birth and development of the child appear to have been normal. The mother and father have been married since the patient's birth. At the age of 1 year the patient had whooping cough associated with spells of unconsciousness, during which he would stiffen out and get blue around the mouth but had no convulsive movements. These spells would last about 10 minutes. At the age of 2 he had mumps and a very severe convulsion, followed by unconsciousness, which lasted nearly eight hours. It is not clear from the information obtained from the mother whether he had a series of convulsions or not. Later he had measles, followed by another convulsion, which was not severe in character.

The child goes to sleep quickly when put to bed but often wakes up and stays awake two or three hours in the middle of the night. Waking periods are not caused, so far as can be determined, by dreams. He has a poor appetite and refuses to eat spinach and other vegetables. He has to be coaxed, and frequently mother has to sit down and feed him. Once or twice a week he is troubled with enuresis but never during the day. He persistently sucks his thumb and his first two fingers. The mother is much disturbed because the child masturbates. She feels that this is probably due to the fact that the father has the same habit. The child has been reprimanded and punished for this habit.

He has a violent temper and stamps and cries when he can not have what he wants. His mother finds it very difficult to manage him, although he is apparently very much attached to her and always makes an effort to protect her when her husband abuses her. He is very shy on meeting strangers but gets acquainted with comparative ease. He is very generous with the family and those outside, not at all jealous, is fond of his father and is quite delighted when he pays any attention to him. He gets along well with other children and is not pugnacious, yet he stands up and fights his own battles. He plays at home a great deal of the time. He has never attended school. His intelligence quotient is 88, which is, apparently, a fair estimate of his intellectual endowments. It is extremely difficult to hold his attention.

It appears from the history that the father is lazy and shiftless and takes no interest in the home although the patient is devoted to him. He never buys the child anything and rarely devotes any time to him. He contributes nothing to the support of the family except the rent, which he allows to go unpaid to the point where they are evicted. The mother is a fairly intelligent, hard-working woman. She takes in washing and works by the day in order to support the child. She is very much discouraged over the present home situation.

The family live on a narrow street. They have a three-room apartment on the second floor. The house is fairly clean but far from comfortable.

From the foregoing it appears that this child's instinctive life has in no way been affected by training and habit formation. As wretched as the environmental situation may be, it is unusual to find so many disintegrating factors in one personality. The repeated convulsions may, in themselves, be some criterion of the instability of the nervous system. On the other hand, this instability would probably not have had as many grave manifestations had the environment been better. The patient's fondness for his father leads him to imitate as many of his words and deeds as his immature years will permit. This fondness, in itself, may be responsible for the beginning of the habit of masturbation and also for the fact that he calls his mother the same vile and obscene names as he hears his father use.

His manifestation of temper is quite like his father's. Recently his mother bought him a boat for a present when he apparently wanted a bunny. When he got on the car he was shown what she had bought him for a present, and he screamed and yelled, stamped on the boat, caused a scene, and had to be assisted off the car when his mother left. When he came to the clinic a few days later he told the whole story in detail. He said, "Papa calls mama bad names, and Teddy [his little friend] calls his mother bad names. That is why I do it."

The patient presents an unusual and interesting reaction toward soiling his clothes. He said he did it because his mother whipped him and admitted telling her he was soiling his clothes even while he was doing it, stating that he had asked his father to take him to the toilet but he refused. The youngster has an unusual interest in the matter of the toilet and tells of seeing people in the bathroom, says he watches them go in and out and peeps through the keyhole. Probably much of this is subjective on the part of the

patient rather than objective, yet some of it, at least, is due to the intimacy of the household.

For three months the patient continued to get along poorly, but there was just enough improvement in one or more of his numerous habits to keep the mother encouraged. The bed wetting practically ceased, occurring only occasionally. The masturbation stopped entirely, but the feeding difficulty and disobedience continued.

At the time of the mother's last visit to the clinic (June 26) the following note was made: "He has been very irritable of late, and I have been more so." The intense heat has made tenement life very difficult. The mother shows extreme anxiety about the patient and says, "He is different with everybody else—it is only me that he raises the devil with. He gets along with other people, but he certainly is a holy terror on wheels with me."

It is very hard to evaluate the situation properly from what the mother says. The home life is so difficult that she is bitter and cynical. She keeps saying, "He is an obstinate child, but I'll break him of it. He's got to live in the world as I have lived." One is confronted with a very difficult problem. The father goes for days without speaking to the family and pays no attention to the patient. He is seldom at home and contributes little but criticism. Every effort must be made to get the child away from the environment.

Comment.—There is no case that has come to the clinic during the last year that has received more time and attention than the one just cited, and up to the present time little or nothing has been accomplished in its solution. Notwithstanding the fact that the mother has been extremely interested and anxious to cooperate in every way, it seems that the marital troubles and associated difficulties have been more than she could be expected to meet without being absolutely discouraged. Unless the environmental situation is altered in some way it seems practically impossible to obtain satisfactory results or even improvement in this particular case. The evidence of an unstable nervous system manifested by convulsions and the fact that the child does not benefit by repeated experience make one fairly safe in prognosticating that in 10 or 15 years this child will be called constitutionally inferior and will be quite unable to adjust himself in a satisfactory manner to the demands of society. He will belong to that large group of misfits who eventually find their way to jails or prisons, or if more fortunate, eke out a living in much the same way the father is doing at the present time—earning enough money for shelter and depending upon others for food.

TEMPER TANTRUMS.

In the consideration of conduct of which temper tantrums in the child are but one aspect it is necessary to appreciate fully the different planes upon which moral conduct is enacted in relation to the age of the individual and the stage of social development.⁵ Those who deal with children are concerned very largely with conduct carried out on a low moral plane. The child is fundamentally selfish, and consequently everything is interpreted in terms of self, and his own acts as well as those of others are evaluated by the amount of pleasure or pain they bring to him. No moral judgments are formed, and during the early years of life the child does not think of himself in relation to others. He must learn by experience that a certain line of conduct is a paying proposition, so to speak, and that another line of conduct does not pay, and by paying one implies a material gain to the child. With proper training and in the proper environment the average child soon learns that conduct which embraces a consideration of those with whom he comes in contact in his everyday experiences brings him more pleasure and less pain than he would otherwise obtain. He does not take long to learn that certain experiences are associated with definite pain—for ex-

⁵ No more practical exposition of this subject has been presented than that of Professor William MacDougal in his *Social Psychology* (Fourteenth Edition, Boston, 1921).

ample, touching the hot stove—and ordinarily he learns in the same way that little or nothing is to be gained by what is commonly called a temper tantrum. Such a tantrum has been described by a parent as follows: "The child lies down on the floor, yells, kicks his heels, and throws his arms about with the intention of inflicting bodily harm on those who come near him."

This type of reaction, of course, is purely instinctive and must be met on its first appearance in such a way that the child will be firmly impressed with the fact not only that nothing will be gained but that such an experience is a positively painful one, painful in the sense of a definite loss to the child or in a way similar to the experience of putting his hand on the hot stove. This crude and more or less undesirable method of directing and inhibiting conduct during the early years of life should be discarded at the earliest possible date by appealing to the child's love of approbation, which manifests itself probably at the third year but does not become well marked until two or three years later. Here our attempts are directed toward achieving the conduct desired on the part of the child by appealing to his desire for praise, on the one hand, and his desire to avoid blame, on the other. It is at this age that we have been able to utilize a chart system in our clinics, which acts as tangible evidence to the child of the approbation of the doctor and the parents and those whose praise he most desires.

Tempers, as was said before, are usually physical manifestations of the emotion of anger, which may be stimulated when any of the varied instinctive reactions are thwarted. It is important to know this when attempting to understand the tantrums of the child, because it is frequently necessary to determine the cause of the anger, which many parents tell us they are unable to account for. It is only after the child, through training and experience, has developed various means and methods of meeting and overcoming his difficulties, that the emotion of anger ceases to be one of the most dangerous stumbling blocks. The instinct of pugnacity, of which anger is the associated emotion, is essential in the development of most successful individuals. It is that driving force to which much of the success in human affairs is due and should not be stifled out of existence, but must be controlled so as to work to the advantage of the individual.

In every case that involves outbursts of temper it is absolutely essential to study the environment in which the child is being reared, to know under what conditions and in what places and with whom these tantrums are most common. It is of equal importance to make a careful personality study of the child in order to understand as fully as possible the conflicts that he may have and just what purpose these emotional upsets serve. It is futile to treat each outbreak symptomatically by punishing the child or by permitting him to gain some undesirable end. Either method is doomed to failure. Such conduct must be interpreted in terms of the child's experience if his personality is to be molded so that he will be capable of making a satisfactory social adjustment in later life.

CASE No 9.—H. H., aged 2 years 5 months. Birth was normal. Breast fed until 23 months of age. Mother states that it was very difficult to wean the patient, as she cried so much and went into such temper tantrums that the mother nursed her until three months before the younger child was born. Teething, walking, and talking all developed normally. At birth the child had

an umbilical hernia and had to wear a truss. She has had none of the children's diseases, and has had no injuries or operations.

She refuses to go to bed unless accompanied by either father or mother. She retires at 8 or 9 p. m. and sleeps until 8 or 9 a. m. Two or three times during the night she wakes up and screams. Her mother says, "She is probably having temper tantrums in her sleep and is dreaming that she can not have what she wants." There is no feeding difficulty—she eats everything that is given to her—but there are some indiscretions in diet, such as serving tea for lunch. Enuresis occurs occasionally. The child has been known to masturbate and for the last year and a half has been using a small stick to irritate the clitoris. Her mother says that the child has a "terrific" temper; that she will lie on the floor and kick and scream on the slightest provocation. When she does not get what she wants to eat or is crossed at play she develops one of these tantrums. Sometimes they occur when mother has no idea what the exciting cause may be. They occur frequently when she is playing with other children. Following one of these tantrums the child has had "peculiar attacks," getting blue in the face, the mouth remaining partially open, and the body becoming stiffened. These spells last about 10 minutes. During the last two weeks she has had seven such attacks.

The policy now pursued by the family is one of acquiescence. The patient is said to be generous "when she wants to be," is jealous, does not want others to have things she can not have, does not get along with other children because she is pugnacious and fights them, "is always very bossy and domineering and always makes other children playing with her do what she wants even if they are twice her size." She is afraid of the dark, will not go to bed without a light; is afraid of animals, especially cats and dogs. At times she has shown marked affection toward her father. Her father takes no part in disciplining her, and her mother has found that corporal punishment avails but little.

The father is Italian and the mother is Irish-American. The mother states that the father considers her an idiot and has been brutal to her. She does not know how much he earns. He is very close with his money and gives her a dollar a day on which to run the house. He spends but little time at home. The mother feels superior intellectually to the father and is always conscious of the racial difference. She states that father hates their older daughter, but is devoted to the patient, whom he fondles and pets. He is also quite indifferent to the baby. They live on a short, paved street in a three-story brick tenement house. They have a two-room apartment on the first floor. Father, mother, and patient sleep in a double bed, while Mary sleeps on the davenport. The mother furnished the house with her own money, and it is fairly comfortable and well kept.

Prior to their marriage the father and mother lived in Boston as man and wife. Even at that time he was extremely cruel and abusive to her, and very irritable, and would throw cups when things he desired were missing at the table. Even at this time he was keeping company with another woman. The father was arrested in 1918 and sentenced for three months. Their quarrels were frequent, and in self-defense she has scalded and bitten him. Although he is still very rough and shows temper and drinks a great deal, he has not used physical violence of late. The mother knows that he is not true to her and questions his relations with the patient. There is a story of the father's having infected the older daughter with gonorrhea when she was 4 years old. His sexual demands are excessive, and he masturbates frequently.

At the clinic the patient appeared to be a quiet, demure, neatly dressed little girl, who sat quietly by her mother until she left to enter the examining room. The child then went into a violent tantrum, lying on the floor, kicking her heels, and yelling at the top of her voice. This behavior continued during the half-hour interval while the mother was talking to the physician, but it was not followed by one of her spells. The mother verified the history as given by the social worker and said that the child had been "cranky since the day she was born, always crying and whining." She said, "I could not do a thing with her—she has never slept soundly. I always have to lie down with her and sing her to sleep." Sometimes the patient stays up until 10 p. m. and never has a nap. When patient gets jealous of other children she tries to inflict pain upon them. Whenever her mother pays special attention to other children in the neighborhood or to the patient's sister, she gets into a violent temper, bites her sister, pulls her clothes, and tries to bite her mother.

Her mother repeated that she was afraid the patient had learned to masturbate from her father.

Treatment. Treatment of this case is still under way. The problems of enuresis and of establishing routine hours of sleep were attacked first. The mother was instructed to see that the child was put to bed at 6 o'clock and that she remain in bed at least 12 hours. She was warned against all the difficulties that would arise in starting out on this program, but she was told that they would be only temporary and slight as compared with the trouble ahead if the child was not taught to appreciate that tempers can not be used successfully to get her own way. The routine method as described for enuresis was to be followed, and a chart was given the mother for the purpose of keeping a record rather than to interest the child. At the end of two weeks the mother returned to the clinic, stating that she had instituted the 12-hour sleeping régime but found it impossible to carry out the measures suggested for breaking the habit of enuresis.

The situation is particularly difficult because the child cries violently and the tenant downstairs comes up and threatens to have them put out, and the neighbors become irritated. The father tells the mother she has no brains—what can she expect of the child? He thinks coming to the clinic is a waste of time. Under such conditions it is too much to expect the cooperation necessary for improvement. Jealousy and pugnacity continue, and the patient, on one occasion since her last visit, had a violent temper tantrum on the street. The mother states that, to her knowledge, the child has not masturbated since the last visit, and she is encouraged by the improvement which followed the routine hours of sleep.

Comment.—This case illustrates one of the difficulties of instituting treatment that may cause more or less temporary annoyance, not only to the family but to the neighbors. It is not to be expected that a mother will get up two or three times a night to awaken a child, knowing that such a disturbance of the child's sleep is to be followed by a violent temper tantrum on the part of the child and that, in turn, by threats and insults from the neighbors and her husband.

It is hoped that the time is not far distant when facilities will be afforded for taking such children out of the home and training them, temporarily at least, under conditions more favorable.

CASE No 10.—I. I., aged 2 years 8 months; birth and developmental history negative. She always enjoyed good health; sleeps well; has well-established toilet habits; has a poor appetite and is very finicky about food. Her mother always has to supervise her feeding, and she refuses to eat cereal, eggs, or oatmeal, but is very fond of meat.

The child spends much time sucking her fingers, especially when moody. She is active and interested in outdoor activities. She enjoys being with other children in spite of the fact that it is difficult for her to get along with them. Only on unusual occasions does she have an opportunity to play with children other than her younger sister. When the opportunity arises during the summer months when on vacation, she meets every unpleasant situation by developing a violent temper tantrum. She is domineering and always wants to be the boss. She is considered a fighter and is rough and pugnacious toward smaller children. She whines constantly, and it is frequently difficult to determine just what she wants. She will lie on the floor and kick and yell, and is extremely irritable and impatient. After getting the object for which she has tenaciously fought she will throw it away immediately. She is very destructive. Only recently has she been afraid of the dark. This fear developed subsequent to the following incident. While her father was playing with her she ran into a dark closet, and her father stood outside the door making a noise like a cat. She seemed to enjoy it at the time and asked him to continue. Since this incident, however, she has refused to go to bed unless the door is left open. In spite of her apparent lack of affection, she makes heavy demands upon her mother's time and wants to be constantly by her side. She rarely shows any affection toward either parent and only utilizes kisses to get out of some situation which is apt to be followed by punishment. She is rough with animals but not cruel. Toward the baby in the household she is ordinarily kind and generous but, at times, is rough and pushes and slaps her. Her mother admits that she does not spend much time or affection on the child, saying, "I am not naturally affectionate, and my husband is more interested in the children." The mother is of average intelligence and appears interested, but one feels that this interest is rather superficial and that one of

her fundamental characteristics is to take the path of least resistance. For example, she meets the finger sucking by giving the child a bottle.

Comment.—The outstanding features in the foregoing case are the unaffectionate attitude of the mother toward the children and the indifference the child shows for the parents. The child's negativistic attitude toward life stands out very prominently. She is always on the opposite side. In other words, she belongs to a group of children who, between the ages of 3 and 5, develop what may be termed contrasuggestibility.

This condition in children usually lasts but a short time and passes away without any undesirable effects upon the personality. On the other hand, there are many individuals in adult life who are chronically negativistic, with whom any suggestion from an outside source immediately prompts them to take the opposite side of the question presented. Many of these individuals develop unusual ways; their habits of living, of dress, and of eating are all such as openly to defy custom and tradition. In children this negativistic attitude regarding food, sleep, and general conduct is often difficult to explain, but frequently it represents an effort on the part of the child to attract attention and to keep himself in the limelight and perhaps to hear himself discussed. For invariably these negativistic children are pointed out by the parents as "simply impossible youngsters."

It seems wise when this negativistic attitude is first recognized to minimize it so far as possible, to see that the child gains nothing by such reactions but rather that they work out to his loss, and above all, never to discuss in the presence of the child his apparent peculiarity. This is one of the situations in which the child must be led and not pushed.

This case brings out the importance of allowing children to associate with others of their own age. One of the most fundamental and important instinctive forces is that which is commonly termed the herd instinct. Very early in life the child is capable of benefiting greatly by associations with other children. He thus has an opportunity of seeing his own acts mirrored in the reactions of those of his own age and is able to get a better understanding and develop a more sympathetic attitude toward others by virtue of this understanding. So it is not surprising to find that the child who has been confined to his own household 9 or 10 months in the year, making contacts only with those in the family, experiences great difficulty in understanding and getting along with others when the opportunity arises. In these days, when the hazards arising from automobile accidents in the crowded, congested districts can not be ignored but must be considered by every interested parent, the nursery and the nursery school will be able to afford the desirable opportunities for youngsters to get together, and in the performance of their simple tasks, in their play life, and in the educational training, they will learn much concerning the problems of everyday life as they are related to the group rather than to the individual.

Although not yet 3 years of age, this child is rapidly developing into a cold, calculating, unaffectionate individual, who utilizes pretension of affection toward others entirely to gain her own ends. This attitude, of course, but reflects that of the parents toward the child, and it is not surprising that she utilizes such an asocial reaction as temper tantrums and negativism to keep from being obliterated entirely from the family horizon.

The treatment in this case deals primarily with the mother. She manifested more interest than the foregoing history would indicate that she was capable of; and as she is of an intelligence above the average, the situation seems quite hopeful. The treatment of such a case must continue over a period of several months. Much can be expected when this child enters the nursery school in the fall and makes daily contacts with other children. Much has already been accomplished by presenting to the mother the program to be followed and changing, as far as possible, her attitude toward the patient.

PUGNACITY AND SHYNESS.

CASE No. 11.—J. J., 2½ years old, was sent to the clinic from the nursery school with the following statement: "He has a bad temper, is always fighting, strikes and slaps other children without provocation, and always wants what his brother has and fights for it."

In the attempt to determine the cause of this exaggerated pugnacity, what appeared to be rather contradictory statements regarding the patient's older brother, Henry, aged 4, were encountered. The home life of the two youngsters

was very unhappy and chaotic. The mother and father were always fighting, and both were said to be impulsive and quick-tempered. The father has been arrested for assault and battery, and the mother bore scars of his cruelty on her first visit to the clinic.

It appears that John, the younger, has always been "mother's boy" while his older brother, Henry, has been the father's favorite. From the nursery school it was learned that the older brother is very sensitive and extremely quiet, that he is absolutely obedient and more polite than other children. At times he is troubled with enuresis and stammering. The mother's story, however, is quite different. She claims that Henry is bossy and domineering, always wants his own way, is jealous of the younger brother, has a violent temper, and sometimes bites other children when he gets angry. She further states that he has an intense fear of her, and when she "explodes in anger" or threatens to punish him "his legs actually shake."

When the mother's attention was drawn to the discrepancy in the descriptions of the personality of Henry she said that the picture which she had given the previous week "is only true when he is having ill turns" and that usually he is extremely timid and never asserts his own rights, that John will "knock him down and walk all over him and Henry never makes any resistance whatever." He is extremely affectionate and likes to be petted, is afraid of the dark, where he "sees things and people."

In the examining room, Henry seemed very quiet. He had a marked hectic flush and breathed through his mouth because of a profuse mucous discharge from both nostrils. The cervical glands were enlarged, especially on the left side; and there was enlargement of the adenoids and tonsils. The lad was underdeveloped and poorly nourished. He was immediately referred to the medical clinic, and the mother was requested to return at the end of 10 days.

Careful social investigation revealed the following facts: The father and mother were "always scrapping." They were living with the maternal grandmother because the father did not support or provide for the mother. On several occasions the father has been arrested for assault and battery. The grandmother reported that there are two distinct factions in the household. The younger child, pugnacious John, is lined up with the mother against the father and timid Henry. Because of the father's work during the day and his pursuit of pleasure at night he spends but little time at home. Consequently Henry is left alone pretty much to fight his own battles. The mother at all times has been the protector of John, and he has learned from experience that he can tease and torment his older brother without fear of retaliation when his mother is about. Henry undoubtedly has learned that it is the better part of valor to succumb to the inevitable torments of his brother rather than to raise the wrath of his mother. So day by day the younger lad has become more domineering and pugnacious while the older boy has become more subdued and submissive, only occasionally turning upon his brother and at such times biting and scratching in a crude, instinctive way. This is not mere speculation but is borne out by the fact that John has improved rapidly since entering the school, where he has less opportunity of manifesting his arrogant, domineering ways without punishment. Henry, on the other hand, has retained his shy and diffident manner.

Comment.—The two important points brought out in this case are: (1) The one concerning the effect of environment on the development of personality and (2), the importance of certain types of symptoms in making a prognosis. The question is constantly brought up that if environment is such a tremendous factor in the development of personality, why is it that two individuals coming from the same environment should be so diametrically opposite in character and disposition? This case seems to bring out the fact that it is not so much the environment as such that counts but the mental atmosphere of the environment in which the patient is to live. Here were two boys born of the same mother and father, reared in the same social heritage, but for whom the mental atmosphere of the home was entirely different. One lived an absolutely sheltered life, basking in the affection of an oversolicitous mother, while the other lad was living a life of torture, being subjected to the torments of the younger brother and to the persistent reproaches of the mother. It is not difficult to understand why these two children should have developed entirely different personalities, one characterized by a domineering pugnacity and the other by submission and a feeling of inferiority.

With reference to the second point, the prognosis is always discouraging when the individual's personality defect has caused his retreat from contact

with humanity. Such a personality defect deprives the individual of the opportunity of developing new interests outside of himself. It takes away the necessity of effort at social adjustment and gives him time in which to build in fancy, life as he would have it. The individual who remains in the active voice, keeping in contact with the herd, has ever before him the opportunity of learning life's lessons by experience and by the necessity of adjusting himself to the demands of society.

CASE No. 12.—K. K., a colored girl, 2 years 9 months of age; birth and developmental history quite normal. She has always had good health except for measles and bronchitis when 2 years old.

Habits regarding food have given considerable trouble; until the beginning of the second year she always had to be coaxed; had to be forced to eat at times; was very finicky about carrots, spinach, and other vegetables, but mother "persuades" her by "showing her the strap." She eats plentifully of what she wants. Her toilet habits have been established. The patient is very kindly disposed toward everybody, gets acquainted with strangers easily—both children and adults. She had shown a tendency to be cruel; she would punch the other children and at the clinic would frequently knock them down when they crossed her path. She has a very quick, violent temper and gets angry when thwarted. She is extremely jealous of her younger sister because her father would tell her he loved the baby better. When scolded or humiliated she puts her fingers in her mouth to keep from crying and before going to sleep always indulges in a period of thumb-sucking. The mother has kept the child in the house most of the time on account of her marked pugnacity and the difficulty that she causes with the neighborhood children.

At the clinic she was extremely active and mischievous, teasing her mother by pulling at her dress and then running away, pulling down the curtain, and doing numerous other things for which the mother was constantly reprimanding her. She was openly rebellious toward any discipline and defied the mother when any effort was made to thwart her. Instead of crying or whining for what she wants she pushes and fights her way until she gets it. When attempts are made by the mother to punish her she runs away, dodging and ducking into the corners and under the table, and when finally captured and punished by the mother, shows no resentment whatsoever. After she is completely exhausted she goes to the corner, sits down, and begins sucking her right thumb and twisting her curly, black hair between the fingers of her left hand, apparently perfectly happy and contented.

The psychologist stated that it was impossible to get any measurement of the child's intellectual equipment as she is too active and unruly; she consented to look at one of the pictures, but her interest lasted only a moment. She is described as appearing to be a bright, hyperactive child who demands her own way at all times, expresses her ideas clearly in sentences, and plays with the pencil and paper. She was interested in everything that was going on; showed marked curiosity; and when opposed, did not hesitate to scratch, bite, and kick.

The patient's father is a hard-working man enjoying good health and earning an adequate salary to provide well for the family. The mother is also in good health and has a fair intellectual equipment, having gone through the seventh grade in school. Since coming to this country from the West Indies she has gone to trade school and learned dressmaking. She has worked as housemaid and in a laundry. She is much interested in her children but not particularly cooperative so far as the clinic has been concerned.

Summary.—We are dealing with a child not yet 3 years of age, having a normal mentality, coming from a home which presents no outstanding defects regarding the physical surroundings and social relationships. The most prominent characteristic in the mental life of the youngster is her curiosity and tendency to investigate, a marked hyperactivity and restlessness displayed both at home and at the clinic. Much of the pugnacity which has been attributed to the child seems to be due to her desire for action rather than to any desire to cause pain to others. Under existing conditions the mother has felt obliged to limit the field of activities to their four-room apartment, which is quite inadequate to meet the demands of the child. It seems that much of her mischievousness and naughtiness, so-called, can be attributed to her desire for play life and that it is not associated with any unpleasant emotional reaction. To defy and be rebellious is her method of stimulating her mother to activity; to be chased and given the opportunity of romping and running is the child's motive. One may well expect that in the fall when the child enters the nur-

very school and is given an opportunity to express herself in the group games and rhythmic dances accompanied by music most of her present difficulties will be adjusted.

It is always important to study carefully the motives for acts rather than the acts themselves.

DESTRUCTIVENESS.

CASE No. 13.—L. L. is a very attractive little girl, 10 years of age, whose medical history presents nothing worthy of note. She is in grade 4A in school, and getting on well, which may be taken as a measure of her intellectual capacity.

She was brought to the clinic by her father, who stated that she was "viciously destructive" and "willfully stubborn." He gave the following details concerning recent happenings.

All during the winter she had persisted in going down into the cellar and turning on the cold water, permitting it to run into the steam boiler and thus cooling off the house. For this she was severely scolded, threatened, and spanked, and finally her bare hands were placed in the hot furnace so that they were badly blistered and had to be bandaged for several days. Fifteen minutes after the removal of the bandages the act was repeated.

Four days previous to her visiting the clinic, for some unknown reason she took a pin and scratched the piano. This episode was followed the next day by the mutilation of the top of the dining-room table with the cover of a tin can. For these two offenses, the father scratched the palm of her right hand and arm with a pin, leaving ugly-looking wounds, which were much in evidence when I saw the child.

Recently her father missed several graphophone records, and upon being appealed to the patient admitted taking them to school but did not return them, although her father requested her to do so. Her father went to the school and saw both the teacher and the principal, to whom the patient stated she had given the records, only to have her admit later that she had lied. She was severely switched about the legs on their way home from school but maintained a sullen silence until the next day, when she told the housekeeper that she had put the records down through the cracks in the veranda. A carpenter was secured and several boards were removed, but no records were to be found. A few days later, of her own accord, she produced the records, which had been hidden away in her room.

She writes on the wallpaper, hammers the walls, and destroys furniture.

She is the oldest of five children whose mother died three years ago. Her father states, "I have had 20 housekeepers since then." The one in charge now is 63 years old; she is kindly and affectionate toward the patient and the child is fond of her. The father is a stern, reserved, quick-tempered man who is trying hard to keep his family together and, in spite of his apparent brutality, wants to do what is right.

At school the patient is considered bright, well-behaved, and truthful. At home she is untruthful, disobedient, destructive, selfish, jealous of material things, unaffectionate, and stubborn and resentful. Her father says, "She is willing to undergo any pain to aggravate me."

At the clinic she appears to be a happy, cheerful little girl, who admits frankly her jealousy of her younger sister, who gleefully tells about school-day experiences but suddenly becomes sad and tearful at the mention of her mother. She assumes the responsibility for "all the rest of the kids," as she calls them. She is interested in her schoolmates. She wants pretty clothes and likes her teachers, the housekeeper, and her father. She shows no resentment for the severe punishment she has received and offers no excuses or explanations for her misconduct.

She seems to be very friendly and approachable. One feels that there is a sympathetic relationship established which will do much to get things going right. The father is given to understand that punishment is useless, a fact which he has appreciated for some time. He is asked to get on a more companionable basis with the children, and last Saturday he demonstrated his good intentions by bringing three of the children to the clinic en route to the movies. The report of the father at this second visit was quite encouraging. The patient had been "getting along fine" for a week, none of the destructive tendencies being even in evidence. She seemed happier and more cheerful, talked more freely, and was much overjoyed at the prospect of going to the movies.

After the picture show, the patient returned home. Everything seemed to be progressing well when suddenly, for no apparent reason, she gathered up several phonograph records and destroyed them. There seemed to be no particular emotion attached to this episode, it being apparently the result of an impulsive idea. She was not punished on this occasion, and everything went along smoothly for 48 hours, her father still hopeful that another week might pass by without further manifestation of her destructive tendencies. Monday evening he brought home a new pair of white shoes, a present for which she had shown a strong desire for some time. She was happy over the gift, but within an hour after her father's return she cut the upholstering on one of their best chairs in the living-room with a pair of scissors. This information was given me by the father over the telephone. He admitted that he had reached the limit of his patience and said that some plan must be made whereby the child would be taken from the home.

Arrangements were made with the New England Home for Little Wanderers in Boston to take this child for an indefinite period, and although the father had demanded that such a plan be made, he let the matter drop at that point.

Nothing else was heard from the case until six weeks later when the Society for Prevention of Cruelty to Children was notified that the neighbors were much disturbed the previous night by screams coming from the home of the patient. Upon investigation, they found that the father had been whipping one of the younger boys severely. They threatened to break in, and the father explained that the boy had been damaging the furniture in much the same way as the patient had done. The father admitted that he had a violent temper and sometimes lost control of it. It was generally agreed by those interested that the children ought to be placed out, but the father would not consent.

However, a plan was agreed upon and carried out whereby the children would be sent to Maine for the summer months. Such a plan, of course, is but temporary, and the problem must be faced upon their return home.

Comment.—This case was not under the personal observation of the author sufficiently long to enable him to formulate any definite ideas as to the underlying mechanism for the cause of the child's destructiveness. There are, however, several pertinent factors in the history that give one an inkling of the line of treatment that must be followed. The first and most important is the child's devotion to her mother, her inability to assimilate into her own life the situation caused by the mother's death, and her bitterness and resentment on being deprived of her mother.

In a superficial examination of the facts presented it is found that all the destructive tendencies of this patient are directed toward the house in which she lives and the furniture contained therein. At school, when visiting, or under any circumstances or conditions not found in her own home, she never manifests any of these destructive tendencies. It seems that it is the association with her own home that brings out all of her vicious tendencies. One also finds from the history that for many years prior to the death of the mother the sole interest of both parents was to save enough money to build a house that would be more or less of a show place in the community in which they lived, a small unattractive village in the suburbs of Boston. Both parents worked without daily recreation or vacations and even went without the necessities of life, until the death of the mother, in order that another dollar might be put away. It was, however, only after the death of the mother that the father finally erected the \$16,000 house which stands out as a monument of his ambition and thrift. But somehow one can not but feel that, to the patient, consciously or perhaps unconsciously, it is but a memorial to the toil and sacrifice of the mother for whom she always showed a very strong attachment. This may be considered merely speculative, considering the little opportunity the writer had to observe this particular case, but it is not unreasonable to expect to find an explanation for these apparently voluntary vicious acts of destructiveness in some deep-seated mental conflict with which the child is struggling blindly.

CASE No. 14.—M. M., aged 4 years 8 months; birth and development normal.

He was nursed by his mother for three months and from that time on was a difficult feeding problem. When his mother's milk gave out, he refused to take the bottle; had a great deal of nutritional disturbance. He has been a restless sleeper until lately, but recently he has been going to bed at 7 p. m. and sleeping well until morning. Occasionally he has terrifying dreams, during which he has typical night terrors. These are very apt to follow some

definite incident, such as being frightened as he recently was by one of the neighbors, who told him of the bogey-man. He eats well. There is no history of enuresis or masturbation.

The general health of the patient has not been particularly satisfactory. Besides having a severe nutritional disturbance during the first two years of his life, he has had several convulsions, the first occurring at the thirteenth month, and others at intervals of about six months. The last one occurred in November, 1921, while he was at the hospital; it was reported as being definitely epileptoid in character and lasting 30 minutes.

The patient finds it difficult to get along with other children. He is unduly pugnacious; he gets into many fights and is constantly teasing those with whom he comes in contact. He seems to enjoy playing with animals but usually ends by pinching them and finding various methods of tormenting them. He is extremely stubborn. His mother states that when he is told to do a thing he always does just the opposite. She feels that she can not trust him a minute. If she is in the bedroom while he is in the kitchen, he will turn on the water faucet or the gas. He has knocked the parlor lamp off the table and shown other destructive tendencies. If taken into a store he will pick up things and handle them, perhaps grabbing an apple and biting into it. Recently, while at a rest camp, he climbed into an automobile and started it. On two other occasions he has started automobiles on the street. For the above reasons the mother lives in fear and terror of what is going to happen next.

When rebuked he retaliates by using obscene and profane language. Recently when his Sunday-school teacher, thinking he was too young to read, did not give him a Sunday-school paper, he stamped his feet, kicked her, and called her a nasty name. This habit has been growing steadily worse for the last few months. Efforts at home to discipline the child have been fruitless. The mother states, "He is just one of them kids that is just smarty. It is his disposition to be that way, and he can not help it." She further comments that in spite of his sauciness, he usually says things with a twinkle in his eye, and everybody likes him.

He has always been extremely active and destructive; loses no opportunity to get into a fight; seems lacking in any appreciation of the rights of others; will enter any of the neighboring houses without knocking and appropriate openly what he desires. At the nursery school he is considered a difficult child to teach, seems unable to follow directions, and has no sense of rhythm or order. He does very poor work and will not obey—is considered a general nuisance. Of late he has been calling his teacher bad names whenever she asks him to do anything.

The family occupy a four-room apartment situated on a busy thoroughfare. The house is well-furnished and homelike, well-ventilated, and neatly kept. Family relationships are unusually pleasant. Both father and mother are much interested in the children and extremely anxious to cooperate in any way possible. The discipline has been left very largely to the mother, who looks upon the patient's behavior as something inevitable and thinks that it is too much to expect results from the clinic.

Summary.—Patient, nearly 5 years of age, for the last four years has been having convulsions at rather infrequent intervals. It is evident from his general reactions to the problems of everyday life and his behavior in school that he is not endowed with a normal intellectual equipment or that if he had such endowment at birth, it has been retarded in its development by the convulsions. In spite of the fact that the home situation is at least average and the parents are cooperative, it is perhaps useless to hope that satisfactory results will be obtained so long as treatment is carried on in the home, where the mother is inclined to take the stand that "what is to be will be." There is every reason to believe that this type of case would be much benefited by institutional life during the developmental period, for not only have we to deal with a youngster whose mental development is somewhat retarded but the whole situation is complicated by the convulsive phenomena and the emotional instability. Under these conditions a very special environment, such as can be obtained only in the best institutions, is needed so that the limited abilities of the child will be developed to their fullest extent.

DELINQUENCY.

The self-regarding sentiment of most individuals is dependent to a very large extent upon the opinion that other people have of them. It is only after an individual has achieved success and established himself firmly in science, business, or a profession that his confidence in his own achievements is such that he can ignore to any marked degree the opinions of others.

During the early years of a child's life, when imitation and suggestion play such an important part, it is particularly important that he should not absorb from those about him ideas of himself which react disadvantageously on his conduct. The child who is continually led to believe that his word can not be depended upon or that he has no regard for other people's property or the rights of others is quite apt to accept this suggestion as representing the facts of the case and make no effort to avoid doing that which he feels is expected of him. On the other hand, suggestion which leads him to believe that he has certain capabilities and that a certain moral standard is expected of him may do much to stimulate efforts which will lead along the desired paths and toward a line of conduct which will in itself furnish the satisfaction to assure its continuance. It is too much to expect that the lad who is being reared in an environment where truth and honesty are held lightly will develop of his own accord standards acceptable to society. No one expresses any particular amazement over the fact that a child brought up in a German family learns to speak German or that the French child learns to speak French, but sometimes the fact is not appreciated that conduct as well as speech is an imitative phenomenon to a very large extent.

One mother brought her child to the clinic, stating quite frankly that the child, aged 3 years, used the same swear words and obscenity that her husband used and that he manifested the same arrogant, defiant attitude toward her that he sees in his father. There is nothing obscure between the cause and effect in this particular case. But another woman brought in her youngster, quite perturbed on account of the fact that the child spent for candy a nickel which had been given her for carfare for a visit to the dentist and told her nothing about it. It was only a week before, however, that this same mother had told the child that she was going on an automobile ride and then had taken her to the dentist. One finds that at a very early age a child is quite capable of differentiating fact from fancy and that one of the first important needs in the development of honesty and integrity is conduct on the part of those with whom the child comes in daily contact which he can safely imitate.

The problem is not by any means entirely one of suggestion and imitation, and frequently very complicated situations arise which do not permit of such simple methods. A little girl was sent to the clinic by the court because of stealing. Investigation showed that the motive in this particular case was that of intense jealousy of her chum, who belonged to a slightly higher social stratum than the patient and had many of the little niceties which young girls crave but which were forbidden to the patient. This feeling of jealousy

had persisted over a period of years, and it was not until she was given charge of the cloakroom at school, a privilege which was assigned her because of her apparent honesty, that this emotion of jealousy made itself manifest in stealing.

Not infrequently stealing in young children has its origin in what Doctor Healy terms "grudge formation"⁶ and in sex conflicts. Such cases call for most careful, intensive study, frequently over long periods of time. They require patience and kindness on the part of the parents and frequently tax the skill and ingenuity of those interested in children's problems before they are satisfactorily adjusted.

The motive for delinquency is the all-important problem, and there is usually little cause for alarm on the part of parents on account of petty thieving in children or their lack of regard for absolute veracity. It is not intended to minimize the danger to the individual if these qualities are permitted to become woven into the fabric of his personality, but most of these acts mean something quite different to the child than to the parent.

Truancy is not a sufficient deviation from normal conduct to be considered too seriously in itself. It is only when truancy represents an effort to escape from an undesirable environment that it should cause concern, and then it is the environment rather than the symptom that must be treated. It is the spirit of "wanderlust" in most youngsters that prompts them to investigate that which is strange and new. To most youngsters it means nothing more than investigating a new alley, making friends around the corner, or going to the "Common"; with the more venturesome it leads at times without the city limits, to the motion-picture shows, or wherever there seems to be anything of an exciting nature going on. Unfortunately most of these early truants are punished after the first offense, which in no way inhibits their desire for future adventure or satisfies the curiosity stimulated by their first adventure. It is only when the moment to return home seems at hand that they recall the last experience. This very often prompts them to remain away from home on account of fear.

Much can be done for these young truants if the fathers can be sufficiently interested to make a weekly pilgrimage to something new and interesting with the child, for much will be added to the enjoyment if the child has someone for a companion whom he can ask innumerable questions. One youngster with the habit of remaining out at night with the other boys, who would leave him one by one, said he was always afraid to return home "to face the music." His mother stated that he had been beaten very hard but that it did no good. Beatings do not solve these problems.

CASE No. 15.—N. N., aged 10; birth and developmental history quite normal. She is the third of five children. She was brought to the clinic by her mother because she told "silly lies" without any reason, stayed out at night without permission, and stole money in small quantities. The child has had measles and whooping cough, but none of the other children's diseases; has no history of injuries or operations; sleeps and eats well, occasionally talking in her sleep but not so as to be understood; and wets the bed at infrequent intervals. The mother states that the child is selfish, always wants her own way, is not affectionate, shows no attachment for father or mother, is extremely jealous of her younger sister, wants everything sister has, and resents mother's show-

⁶ Healy, William, M. D.: *The Individual Delinquent*, p. 376. Little, Brown & Co., Boston, 1915.

ing any attention to the sister. She is constantly quarreling with other members of the family, and is "irritable and snappish." Mother states that she does the punishing with a strap, as the father seldom disciplines. The patient is apparently afraid of her father but not of her mother. She claims that she gets along well in school and gets good marks, but subsequent investigation does not bear this out.

The following comments on the other children in this family are of interest: George, born in November, 1907, is said to be disagreeable, troublesome, and a trial to his mother. In June, 1915, he was arrested for breaking into the Girls' High School with two other boys and destroying microscopic lenses. He was put on probation, and his conduct since has been unsatisfactory. In July, 1919, he was again arrested for breaking into and entering a grocery store, but the case was dismissed. He was always lazy at school, which he left at the age of 14, having repeatedly played truant. After leaving school he worked as an errand boy for six weeks at a stationery store and made \$7 a week. He is now looking for work and spends most of his time on the street. He is scornful and defiant toward his father, and refuses to go to church. Joseph, born in 1910, is still attending school. He was always well behaved until two years ago, and since then he has become irritable when crossed. He was arrested with two other boys for taking a doctor's kit from an automobile and was put on probation. The two younger children present nothing in their physical or mental make-up worthy of note. They had no conduct disorders.

At the clinic the patient appeared to be quiet, subdued, rather well developed and nourished, and fairly attractive. She manifested little interest in her surroundings. When questioned regarding her delinquencies she answered quickly, but judging from the data previously obtained, apparently not frankly. She accounted for the time spent away from home as being with her girl friends and playing with the other children on the street. She said she never asks permission to go out because her mother always refuses it. When she gets out, she said, she is afraid to come home. She appreciated the seriousness of her present situation, and her attitude seemed quite normal regarding her difficulties. She admitted quite frankly that she does not like housework, but said she is willing to do it, since she must. She is looking forward to learning cooking in school next year. She admitted taking money that she finds about the house, stating that the amounts vary from 10 to 45 cents and that she always denies having taken the money, as she wishes to avoid the punishment which always follows. She said she enjoys most being on the street or with her friends and likes to be away from home. She reads little and does not care for the movies.

The following summarizes briefly the home situation. The mother appears to be a hard-working woman, who bears the marks of her toil and hardships. She never had good health and is obviously discouraged with the discord between the members of the family and because of the poor tenement in which they have to live. She has always had considerable worry and anxiety over the oldest three children. Her husband keeps her constantly upset because of his marked irritability, fits of temper, and nerves, which disturb the family most of the time. He is apparently disgusted with the lack of success they have had in raising the family, and there are many scenes between him and the oldest boy. He is always worse when he has been drinking. The patient seems to be his favorite and has considerable influence over him when he is having one of his "spells." The mother tries to accept this chaotic situation as part of the battle, but the alcoholism of her husband and the constant quarreling of the children make her very unhappy. The home situation is quite intolerable. The family occupies a five-room flat in a poor neighborhood on a noisy, crowded street. The tenement is damp and cold and, in spite of the mother's efforts to fix it up, it is not attractive.

The case was first seen on February 23, and during the first visit little was accomplished except to get the history and an interview with the child. The mother was requested to return to the next clinic, but it was several weeks before she appeared again. The report was very discouraging. The child continued to disregard her parents' wishes, paying no attention whatsoever to her mother. She always avoided telling her mother where she was going and where she had been, even if her conduct had been such as to justify praise. Her school work is not satisfactory, and it is expected that she either will have to repeat her grade or take summer-school work.

On the second visit there was sufficient time to discuss the problem in some detail with both the mother and the child. It appeared that the mother's re-

strictions on the girl had been rather severe. Her anxiety over the patient's whereabouts and her distrust of her capability of caring for herself made the mother feel that the only safe place for her was in the house. The family budget was such that the mother felt unable to make any allowance to the youngster at all and invariably refused her when she asked for money. The mother was frank in admitting that perhaps on occasions her irritability toward the other members of the household was spent on Nora, and that she rarely, if ever, had any time to devote to her except for matters of discipline. An effort was made to present to Nora some of the difficulties of the mother's position and the importance of her assuming certain responsibilities in helping out in the household and causing the mother as little anxiety as possible. It was agreed between them that the patient should have an allowance of 10 cents a week and that she would ask her mother's permission before she went out to visit other girls or to play in the street.

The mother did not return until about a month later, notwithstanding the fact that she had been urged to make weekly visits to the clinic. She stated that the patient was doing better, that she was not running away as she had formerly, but that she was still very unreliable about keeping her promises, irritable with the other children, doing poorly in school, and of little assistance in the household. The mother stated that it was difficult for her to get to the clinic more than once a month as her household duties made heavy demands upon her time. The whole situation was gone over again in detail, and an effort was made to have both mother and patient make some concessions.

The following month, when the mother returned to the clinic, although very reluctant about admitting an improvement, she did state that Nora "does not run away any more, and she does not tell silly lies" as frequently. She reported that Nora was very quarrelsome and hard to get along with. Her school work was poor and her deportment mark low. At this visit, for the first time, the patient got a little friendly and confidential. She said that although she did not like her teacher and hated the thought of going to school during the summer, she was very anxious to stay in the sixth grade so that she could be with her brother, who had just failed. She did not hesitate to say that she was pleased over his failure. The child was apparently in a very unhappy frame of mind, resenting authority and feeling that she was not having the opportunity that other children have. Her attitude seemed to be that whatever she gets out of life she has to take in spite of what others think. The mother's attitude impresses one as being absolutely hopeless. She has lost her courage to go on, is unable to see anything bright in the future of the patient, and does not hesitate to let the patient know how discouraged and unhappy she is about the outlook.

The patient did not return to the clinic from July 6 until April 17, when she came in alone. She stated that she was getting along well in school, things were improving at home, and she was getting more confidence in her mother. The mother's report, gathered by the social worker, however, was that of a harsh, pessimistic critic who sees nothing but the unfavorable side of the situation. She had just received a report from the school which indicated absolute failure on Nora's part. Her deportment, writing, and geography were poor, and the mother laid great stress on this failure. Nora, however, by way of apology, said that besides these poor marks, she had received four marks indicating exceptionally good work—a fact which the mother admitted. When the patient was asked in her mother's presence if she was helping in the household, the mother spoke up, saying, "Believe me, she don't do much. She lies and steals money. I don't dare take her in anyone's house for fear she might take something." The mother still refused to give the child money for any purpose, in spite of the promise she had made at the clinic. The patient said she never has a chance to go to the movies, that she gets candy from other children, but never has any of her own—"only what I take. The girls I play with sometimes have candy and sometimes give it to me." She thinks that a little girl of her age should have 10 or 15 cents a week.

The child was given a long talk on the value of honesty, playing the game fair, and helping her mother out. The mother was interviewed at length about the absolute necessity of changing her attitude toward the child. The importance of making the child believe that something was expected of her was called to the mother's attention. It was pointed out that absolutely nothing could be accomplished if she persisted in impressing the child with her delinquencies, especially if this was done in front of other people. The fact that the mother had followed her own methods without success with the

older children was pointed out to her, with brutal frankness, and an effort was made to show her that nothing could be lost if she followed the plan outlined by the clinic.

Notwithstanding the fact that the situation seemed extremely hopeless if the child were to remain in that environment, it seemed to be worth while to continue the efforts in this case. Something about the patient—her honesty and frankness at the clinic as compared with her actions at home and her insight and appreciation of the importance of overcoming her delinquencies—gave encouragement in spite of the wretched environmental conditions in which she was living and poor cooperation from the mother.

The latest reports from the school have been very encouraging. The patient is in the seventh grade, gets along much better than last year, got "one" in effort and "two" in conduct, and has not been sent to the office during the entire year for disciplinary reasons. The patient is frank and free in her talks with the doctor and has lost much of the stubbornness which characterized her first visit to the clinic. Her mother has put her on an allowance of 10 cents a week and recently gave her 30 cents to go to a festival. There is no trouble at home about taking money, and the patient seems to be making a fairly good adjustment. She has passed all her examinations in school and is looking for a job caring for a baby during the summer months instead of having to make up school work.

Although this improvement has been in evidence for a period of only three months and may not continue without occasional relapses, the case is particularly interesting as an indication of what can be done in spite of wretched environmental conditions and lack of cooperation. Besides the rather infrequent visits to the clinic during which the problem had been discussed with both parent and patient, successful effort has been made to get the girl interested in a girls' club and in taking books from the library, both of which give her much-needed interest other than street life.

CASE No. 16.—O. O., age 6 years 4 months, third of four children—the other children being 8 years, 7 years, and 11 months old, respectively; birth and development normal except that talking was delayed until she was 26 months of age and that she has always lisped. Except for an orthopedic operation in March, 1922, on account of a shoulder deformity the child has always enjoyed good health. Prior to this operation she was very restless at night and frequently walked in her sleep, but since the operation her sleep has been restful and quiet. She has a good appetite and is not finicky. She is said to be domineering and quarrelsome and to prefer to be alone, although she is not shy. She is extremely affectionate and sensitive and is inclined to be jealous when she sees others being petted. She gets along well at home—at least her mother says the child is easy to manage. She enjoys her play life and spends much of the time by herself. Her mother denies that the child has any propensity for stealing (in spite of a history to that effect obtained from outside sources), but admits having lost money which she has left about the house. She says she could not suspect the children as she has always trusted them. The child is in the first grade. In spite of her history and although she makes a poor impression on first contact on account of her unattractive manner and unkempt appearance, she grades normal on the psychometric test.

The father and mother are separated, but he occasionally comes to the house to see the children. The mother seems quite devoted to the children, and although the living quarters are poor—they consist of a four-room apartment on the third floor of an extremely dilapidated building—and the home is untidy and cluttered, having soiled dishes and clothing and scraps of food strewn about, she attempts to do more than to give them purely custodial care. She makes an effort to amuse them, occasionally taking them to the moving pictures and for walks.

Olive was referred to the clinic by a settlement worker on account of her persistent stealing and the conditions under which the thefts were carried out. From the settlement she has taken two hats and an umbrella. She is frequently found going through the children's clothes, raffling their pockets. She admits these thefts only under conditions in which it is quite apparent that she must be caught. Even when called to account for having stolen an article, she will make attempts to take things from the person reprimanding her. It matters not whether the articles are of particular value or whether they would naturally interest a child of her age. From the school she has taken beads, a rubber ball, a teacher's key, fruit, and numerous other articles. When con-

fronted by one in authority with the charge of thieving, she invariably denies the thefts but always confesses later on. There seem to be no outstanding problems except the stealing and lying.

The home situation is one of filth and immorality. The father apparently spent much of his time with other women prior to leaving home. He claims that the mother was irresponsible in the care of the children and household, that she used vile language and never had the meals ready, and that the house was always dirty. She, on the other hand, accuses him of having a violent temper, saying that he frequently went into a rage and that there was nothing too mean or vile for him to say. It is quite apparent from the history that both of them have associations of the lowest type. The father, on one occasion since leaving home, came to visit the mother and found her making home-brew. He called in the police and had her arrested. It is quite obvious that little or nothing can be expected in the way of cooperation. The only hope in helping the child lies in those with whom she comes in contact outside the home.

The assistance of her teacher was solicited, and her cooperation has done much toward any improvement that has been made. The teacher states that the patient is a dear little girl and seems to be much attached to her. The child gets along well in school with the other children, but it is very difficult to make her concentrate. She does not seem to have any interest in school, is poor in all her subjects, and probably will not be promoted. At school her speech defect is a great handicap. She is considered very childish for her age.

At the clinic she entered the examining room in a shy and diffident manner but did not appear frightened or resentful. At first she only smiled when asked questions. Soon, however, she became more responsive and, with a marked defect in her speech, began to repeat letters and numbers for the doctor. She volunteered a little information about her home life—the fact that she has two brothers, that her father takes her to the movies, and that she goes to the beach and to school. On the first visit she was very reticent about discussing delinquencies, and the subject was soon changed to one more pleasant. She said she liked to play ball and skip rope but did not like dolls because they break; she likes the dances at the movies and said she could dance; she told of seeing Charlie Chaplin, told the doctor what she had had for different meals during the last 24 hours, named a number of common objects in the room, and gradually became more interested in her surroundings.

A week later the patient returned to the clinic. She was much more friendly but still a little shy. She made an effort to carry on a few speech exercises, imitating the doctor. When asked with whom she played she said, "No one." When asked why, she said, "Nobody likes me." Then she discussed the subject more spontaneously saying that she didn't see why they didn't like her—no one likes her except her father and mother and the baby. Girls don't like her—they knock her down. She insists that she is the only one the other children do not like. She said she didn't like anybody but her family. There seems to be real emotion attached to the idea that nobody likes her. She tried to hold back the tears, but it was difficult. She talked more frankly about her thefts and tried to justify herself by the fact that she does not like those from whom she takes things. At this time she was given a long talk in which she took considerable interest, about how she might make people like her and about playing fair and square and about how she would feel if other people took her things. She was told that a careful record was going to be kept of the days she did not take things and that she was to bring the record to the doctor the following week. The teacher was seen, and an arrangement was made whereby a chart would be kept on which a star would indicate each day that the patient's conduct had been satisfactory. This was carefully explained to the patient. She started off in a happier frame of mind than we had ever seen her.

Just a week later the following report was received from the school: "Olive has been getting on much better during the last week. It was not until yesterday morning that she was found peeping into the school desks in rather a suspicious way. There is no record of her having taken anything that did not belong to her at school all week." At the clinic, however, she found two pennies in the toilet, which she returned with some reluctance. She seemed quite happy while at the clinic and said she enjoyed making the visits.

The following week the report was excellent. The patient was much pleased at the interest the teacher had taken in her and was apparently making a persistent effort to get the coveted stars to bring to the clinic. At the settle-

ment house, however, which she visits frequently, she was found several times in the act of taking things that did not belong to her. Her reaction at being questioned about taking these things seemed one of remorse—she cried and seemed very much upset.

There is something very inaccessible about this child. She chatters away and answers questions very readily, but one feels he is not getting close to her innermost life as yet. The last report received from the school was excellent. "Olive has not taken anything for a long time." She comes into the clinic cheerful, happy, and cleanly dressed. She has a genuine pride in the fact that she has such a good report, and again one feels that in spite of wretched environmental conditions much has been accomplished to help this child overcome two very asocial reactions and get much more happiness out of life.

CASE No. 17.—P. P., a lad 13 years of age, was brought to the clinic by his stepmother, an unusually bright, intellectual woman, extremely fond of and interested in her stepson. For the last five years he has been developing certain delinquencies that have caused the family much annoyance. He began by taking money from the family and doing such trivial things as mailing matter without putting on postage, and short-changing when sent on errands and then telling lies to get out of the difficult situation. He would not, however, persist in the lies but would confess his delinquency, then break down and cry.

About three weeks before coming to the clinic his stepmother lost \$5. About the same time the patient came home and stated that he had got a job in a store. He gave the name of the store, the man he worked for, and the streets where he had to deliver goods. He elaborated to the extent of telling what the storekeeper and the customers said to him, said that he was treated well and was given crackers at the store. At the end of the week he brought home \$5 and turned it over to his mother. Investigation revealed the fact that the lad was not employed and that the money was the same that he had stolen. Immediately after this episode, he made further attempts to take money; that is, he was found searching in places where money was usually kept.

This lad is in the eighth grade and is getting on well in school. The psychometric test showed that he had a normal mental equipment. He has never worked. The father has been generous to the children. They are given a dime on Saturday with which to buy candy and are given desserts at home. He is interested in playing football and baseball, skating and sledding, and gets along well with other boys. He says everyone is kind to him. He admits that he cries easily but knows no reason for doing so. He appears to be an unusually cheerful, active boy who, in the examining room, is frank and honest. He makes no effort to attribute his delinquencies to others. He says he seldom goes to movies and never goes with a gang.

A study of this case showed that the motive was the desire on the part of the boy to emulate his father and play the part of a grown-up in helping to provide for the family. It is what Kirkpatrick has called "passive enjoyment rather than active effort," but the motive was obviously not a malicious one, and intelligent cooperation on the part of the parents made it quite easy to straighten out this lad's point of view. The social-service department of the clinic was interested in this case. The lad's interests were broadened, and arrangements were made for him to spend the coming summer on a farm. The last notes state that he has been completely freed from his former delinquencies and has been getting on well in school and that the family have been relieved of the worry and anxiety which are naturally associated with his former difficulties.

CASE No. 18.—Q. Q., aged 11 years, was brought to the clinic of the Psychopathic Hospital by his mother during the early part of the present year upon the recommendation of the principal of his school. He was under the jurisdiction of the court for having entered a hotel by one of the side windows and taken \$10 from a desk. He denied the theft when discovered hiding in a closet, but finally gave the money up when the policemen arrived. He has stolen many car tickets from the family. There has been a long history of delinquencies.

The patient is a keen, bright lad, with a normal intellectual equipment. He discusses his trouble frankly and is anxious to overcome what we term his "bad habits." He is kind, affectionate, generous, makes friends easily, is interested in all sorts of games and sports, mixes well with the other children, and never holds grudges. He lacks interest in his studies and up to the time of coming to the clinic had never responded to discipline. He has been scolded,

deprived of privileges, and whipped, without results. He has no fear whatsoever of policemen or of going to court.

Through the social-service department of the clinic this lad was connected with the Boys' Club, and supervision was carried on from the out-patient clinic. Results have been extremely gratifying, and the last report of the lad was, "Getting on well."

It is of interest to note that although the parents attributed the lad's delinquencies to an accident which happened about two years ago, the boy's statement is, "My mother says I do these things because I hurt my head and got crazy, but it is because I want sleds and things. My brother used to do all these things; now he is big and he gets me to do them." Frequently parents try to attribute the delinquencies of their children to some sickness or accident, and the children themselves are prone to accept the suggestion as an excuse for doing those things which they enjoy.

ACUTE PERSONALITY CHANGES.

One can not refrain from saying a word with reference to the changes occurring in the personality of the child—changes which develop quite suddenly, frequently following some physical illness or mental upset brought about by some change in the environment. It is a common occurrence for mothers to say, when presenting children to the clinics, that since the child had scarlet fever, measles, or some other acute infection, or perhaps an operation which caused the parents considerable worry and anxiety the child has been quite different. Careful physical examinations usually fail to reveal any cause for this change in personality.

A careful history of the case often points out just where the difficulty has arisen. It is only natural when a child is ill, especially if the condition is at all serious, that the parents (particularly the mother) are deeply concerned. Their anxiety over the welfare of the child is often out of all proportion to what the situation really warrants. It matters not whether the child has been cared for at home or in the hospital, the period of illness and subsequent convalescence is one during which the entire household revolves around the child. The other children are instructed to give in at all times to the ailing member. Every want is anticipated, and his demands, however numerous and varied, are satisfied at the earliest possible moment. He is in a position to commandeer everything in his environment, and, needless to say, it is not an unattractive situation in which the child finds himself. Never since birth, perhaps, has he been the center of attraction, and it is not surprising that he departs with considerable reluctance from the technique which he has utilized so successfully to obtain his own way.

Notwithstanding the fact that many of these personality changes have a definite psychological basis, within the last three years many cases of marked personality change following encephalitis have been noted at the clinic. These changes may manifest themselves in a deep, sluggish apathy or a marked hyperactivity characterized by irritability, destructiveness, and not infrequently violent tempers. Occasionally delusions and hallucinatory experiences are associated with them. Such changes are usually preceded by a fairly typical history of encephalitis, which ordinarily should not be confused with other diseases. There are, however, a sufficient number of mild cases in which the diagnosis of encephalitis was not made that may be followed by change in personality. This point should be kept in mind before instituting treatment.

One mother said, "James is very restless, cries easily, twitches his arms and body muscles, is very irritable, flies into tempers, and can not sleep nights." This change appeared after his return from a general hospital where he had been treated after an accident. He is very surly, always looks ugly, seldom smiles, and appears unhappy and discontented. He has become so different since the accident that the boys have started to call him "empty-head." The problem confronting the mother was whether or not she should follow the advice of her lawyer and sue for damages. However, her primary interest, fortunately, was in the recovery of the lad. Inquiry revealed the fact that since the accident the routine of the household had revolved around the patient. Every whim was gratified regarding his food; other children were notified that they must accede to his every want; all the toys were his to accept or reject as he saw fit; and the lad found himself in the limelight. After a careful physical and neurological examination had been made, it was planned to change the régime in the household. The mother was to revert to the old plan that the patient must give and take and battle for what he could get with the rest of the children. In just one month his mother reported that he was happy and contented and played with the other boys, had lost his surliness, was getting along well in school, and showed no evidence whatsoever of the personality change which was so apparent when he first came under observation.

The following case, discussed in some detail, portrays a similar change of personality brought about by quite a different cause.

CASE No. 19.—R. R., aged 3, was referred to the clinic because of a personality change first noticed on his return from the hospital, where he had been confined with diphtheria. He was quarrelsome, had frequent temper tantrums, during which he threw himself on the floor and kicked and screamed for long periods. At night he refused to go to bed unless accompanied by his mother, and occasionally he had night terrors. In addition there was much capriciousness about food and a habit of soiling himself daily.

This boy's birth and early development were uneventful except for the above-mentioned diphtheria and a mild attack of scurvy when he was a year old.

The father had undergone "a nervous breakdown" a year before. Although he was occasionally irritable he was, on the whole, a generous and considerate father and an excellent provider. The mother was a well-meaning woman but highly neurotic and unstable and had many superstitious interpretations of the simplest incidents. She had lost an older boy through diphtheria and had not fully recovered from her sorrow, a fact which had considerable bearing on her present condition. Besides a younger brother there is in the household the maternal grandmother, who interfered greatly with the discipline. According to the mother, the grandmother "would turn the house upside down to please the children as she hates to hear them cry."

Prior to the boy's illness his mother had noticed nothing peculiar in his behavior, but since his return she had observed a decided change. He was sullen, irritable, seclusive, and unreasonable—expected more than his share of attention and went into a tantrum if it were not forthcoming. He went to the window every night before retiring and, looking upward, bade good night to God and his older brother—a practice which his mother considered uncanny and unexplainable. He had not been permitted to play with the other children in the neighborhood because of his peculiarities and because none of them were near his age. The mother complained that it was impossible to have the child remain in the bedroom alone before going to sleep—he begged her to remain with him to make sure there were no wolves outside the door. He entertained this constant fear of wolves entering the room.

On his first visit to the clinic the boy refused to leave his mother or to permit her to enter the examining room without him. When she left he flung himself upon the floor and remained there in a rigid state until her return. She then picked him up and allowed him to bury his head in her bosom simu-

lating a nursing child. He later began to pout and talk in a baby-like fashion but refused to converse with the examiner.

The intellectual equipment in this boy was about average. He had an intelligence quotient of 98.

This is a case which superficially would impress one as having all the essentials for an early mental aberration, were one to base his conclusions entirely on the mother's interpretations and findings without further analysis of the situation. Indications which the mother accepted as being highly ominous were really nothing more than would be expected in a child of this particular make-up living in such an environment and influenced by a factor which will be mentioned shortly.

The mother, grief stricken over the death of her son (who had died while the patient was convalescing) attempted to compensate her loss by indulging the patient to an unlimited degree. Everything began to center around him. He was the one attraction in the house, and all the members of the household exhibited their joy at his recovery. The child saw himself in this prominent and not unpleasant position, and it was not long before he took full advantage of it by making numerous demands which the family readily granted.

At one time there had been employed in the family a maid who had nightly threatened the child with a wolf story before he went to bed. She utilized this story in an attempt to hasten him to bed, and always warned him to remain in the room, lest he step outside and be captured by the wolf. This bit of information revealed the origin of his fear of wolves.

It had been the grandmother's privilege to prepare the patient for bed. She would undress him, hear his prayers, and, before putting him to bed, take him to the window and have him bid goodnight to his deceased brother, who, she explained, was watching over him with God. When the development of this particular practice was explained to the mother she no longer looked upon it as being a mysterious procedure but realized that it was simply what his grandmother had taught him.

Much of the success of the treatment in this case rested on the mother's acceptance of modern methods of dealing with the child's problem and the destruction of many of the superstitions which had previously handicapped her. After a short psychotherapeutic talk she was found to be most cooperative and willing to carry the treatment out in detail.

A chart was given for food capriciousness, and measures were taken to desensitize the child to fear of wolves. No longer was he to assume the rôle of invalid but was to take his place in the household on an equal footing with his brother.

The patient made three visits to the clinic, and on his last visit his mother reported that he went to bed unaccompanied, no longer talked about wolves, and had earned his complete quota of stars. His marked aversion for milk had been overcome and he drank it unprotestingly with every meal. The family were leaving for a summer resort where it was hoped he would be given a wider outlet and an opportunity for more contacts with children of his own age.

CONVULSIONS.

When one considers that over 50 per cent of the individuals suffering from chronic convulsive disorders in adult life (the so-called epileptics), excluding the definitely organic cases, had their first convulsions prior to the fourth year of life, the importance of convulsions in children immediately becomes apparent. In a recent contribution made by the director of the habit clinics, the problem was attacked from quite a new angle. A group of children under 4 years of age, who had entered the Massachusetts General Hospital, the Children's Hospital, and the Infants' Hospital, having convulsions associated with acute infections, spasmophilia, gastrointestinal upsets, rickets, and whooping cough, were carefully followed up in order to determine the subsequent history of these cases. Of 109 such cases in which we were able to determine to our satisfaction the subsequent history, it was found that over 50 per cent died of con-

vulsions years after they were considered cured, or are still living and suffering from convulsions at the present time, or are mentally deficient. This study in itself is of sufficient importance to lead us to believe that convulsions in children should no longer be looked upon as a mere incident in their medical history, something which happens to every child, like a rise in temperature or a gastrointestinal upset, but rather should be looked upon as a certain criterion of inherent instability of the nervous system.

It is not without significance that there was a certain group of cases associated with encephalitis that had convulsions which ceased as the inflammatory conditions subsided and have not since returned. This indicates that there is a very definite limit to the amount of brain damage that may be done in every case. One nervous system is capable of withstanding a rather severe storm, such as would naturally be produced by an acute inflammatory condition of the brain, and will weather the gale quite successfully, while another succumbs to the acute intoxication produced by the mild gastrointestinal upset, which leaves behind it an increased instability reacting more or less periodically to the minor vicissitudes of life and manifesting itself in convulsions.

From the standpoint of preventive medicine it matters not whether these early convulsions are of psychogenic or perhaps a biochemical origin. There seems to be little doubt in the minds of those most interested in the subject of epilepsy that each convulsion paves the way for the succeeding one and that the path becomes deeper and the demarcation sharper and more easily traversed by the excess of liberated nervous energy. For this reason it is tremendously important for the future welfare of the child that every investigation be made, by both clinical examination and laboratory tests, to determine the exciting factor in the production of these infantile convulsions.

For this reason, too, it is of the greatest importance for the pediatrician and the psychiatrist to work hand in hand. The former sees the child usually over a short period of time but it is an extremely important time, when the undesirable forces, whether they be psychogenic or chemical, are operating. The latter, on the other hand, usually sees the case over a longer period of time but invariably at a period somewhat removed from that in which the exciting factors actually operate. Until we obtain a better working knowledge of this baffling phenomenon called epilepsy, it will be necessary for the psychiatrist and the pediatrician to work together and to have a clearer knowledge of each other's technique. In almost every case of a convulsive disorder we shall have to look for both a predisposing and an exciting factor.

There is no group of cases to-day more worthy of the attention of those best qualified in the practice of medicine than those of early infantile convulsions because, as Sir Leslie Mackenzie stated in a recent report,⁷ "The child, for the first five years of life, is an organism so tender, so easily broken, so easily damaged that it needs all the care that first-class intelligence can give it."

⁷ Mackenzie, W. Leslie, M. D.: *The Carnegie United Kingdom Trust Report on the Physical Welfare of Mothers and Children: Scotland* (Vol. 3), pp. 256-257. Eastport, Dunfermline, 1917.

CASE No. 20.—S. S., a poorly nourished and underdeveloped girl, just over 6 years of age, brought to the clinic by her mother for a series of problems of which fainting spells were the most important.

There is no history of epilepsy or mental or nervous diseases in the family. The child's birth and early development were normal; she has had the ordinary diseases of childhood. There is no history of convulsions, but the mother states that the child, since she was 8 months of age, has had spells, wherein she has lost consciousness momentarily. These fainting spells, so called by the mother, usually take place when the patient finds herself in any difficult situation. When threatened with punishment she falls to the floor in an apparent faint. She holds her breath, gets blue in the face, and the mother then picks the child up, fondles her, puts her on the bed, and the episode is over. At other times these "fainting spells" follow one of her temper tantrums. She lies on the floor, kicks, and yells, for varying periods holding her breath and apparently losing consciousness. She may, however, have one of the temper tantrums without the fainting spell.

The mother states that the patient is very affectionate, although domineering. She always wants "to be the boss," whether at home or at play. In spite of the difficulty that may be involved, frequently resulting in quarrels, she always gets her own way. She is extremely stubborn and when refused responds in the manner described. She is said to be friendly and generous and will share with other children. She is jealous to the extent that she demands at least as much attention as is given to the other children in the family. The mother repeatedly states, "The child must have her own way. The only way to manage her is to give in to her."

Comment.—The foregoing history, in association with the negative physical examination, stamps these "fainting spells" as belonging to a psychogenic group of reactions. It seems quite obvious that the child is utilizing this rather elaborate method (as compared with the temper tantrums) to gain her own way. It is always difficult in a case of this kind to divorce the physiological aspects from the purely psychological. For example, the effect of the holding of the breath on the oxygenation of the blood, in itself, might produce unconsciousness. The fact that the treatment, which dealt entirely with educating the mother in how to deal with the child during one of these "fainting spells" or temper tantrums, completely relieved the symptoms, the child now having gone for over two years without having had a spell (although she occasionally meets an unpleasant situation with the cruder method of tantrums), stamps this case as being purely psychogenic in character.

CASE No. 21.—T. T. may also be mentioned in passing. This child, aged 2 years and 5 months, was brought to the clinic on account of severe temper tantrums, which only recently had terminated in convulsions. When one considers the complete disintegration of the mental life of this patient as indicated by (1) violent temper, (2) insomnia associated with night terrors, (3) enuresis, (4) pugnacity, (5) extreme jealousy, (6) selfishness, (7) destructiveness, and (8) masturbation, it is not very difficult to explain the convulsions as one of the numerous manifestations of an inherently unstable nervous system. This manifestation at times might follow the sexual excitement of masturbation or the extreme emotion attached to a temper tantrum, and at other times might be the manifestation of more definitely physiological causes, such as would be associated with excessive fatigue, lack of sleep, or marked indiscretions in diet. The treatment must be directed not toward the convulsions themselves but rather to rehabilitating the individual as a whole.

CASE No. 22.—The case of F. F. (No. 7), which has been presented in some detail, would have to be studied from the same point of view. The convulsions were so closely interwoven with the marked sexual precocity that it is extremely difficult to separate cause from effect. It is necessary to keep in mind, however, that the patient's mother was an epileptic, a fact which needs certain consideration. On the other hand, the description of the attacks, as presented by the patient, leads one to believe that there is rather a definite emotional element associated with each attack. They are preceded by a choking sensation, which is so commonly described in hysterical cases. They always occur at night, are not considered unpleasant, and have in no way marred the intellectual functions of the patient.

CASE No. 23.—U. U., aged 4 years, was brought to the clinic because he was extremely stubborn and difficult to manage and was seemingly quite insensitive to the praise or blame of those in his environment.

In this case the first convulsion occurred at the age of 13 months and was associated with an acute infection of the influenza type. Since that time, the child has had nine convulsions, occurring at intervals approximately six months apart. These convulsions invariably have been associated with some acute illness, the last occurring May 26, 1923, and associated with an acute febrile condition which lasted several days. Another occurred after circumcision. Several others were in association with definite gastrointestinal upsets at the Children's Hospital. Never in this case have the convulsions been associated with any emotional experience, but they always occurred at such times and under such conditions that it was difficult to explain the exciting cause.

Another important factor in this case is the mental retardation, which is extremely frequent when the convulsions began at such an early age. Mental deficiency of this type should not be looked upon as congenital or due to defective germ plasm. It must be assumed that the child whose nervous system is so unstable that he reacts to an acute infection with a convulsion is somewhat handicapped from the start, but that does not by any means indicate that the child would have been mentally deficient if he had not been subject to the convulsions. We find that many of the physical abnormalities, such as monoplegias, hemiplegias, and spasm conditions in children are not congenital but occur during the first two years of life, following convulsions. This is a practical as well as an interesting point to keep in mind in considering the general subject of heredity.

The treatment in such a case, so far as the convulsions are concerned, is obviously not one of psychotherapy. A special régime should be instituted, in which the amount of physical and mental stress should be definitely limited. Diet is of paramount importance, and all of the more indigestible articles of food and methods of preparing food which render it less digestible should be avoided. Tea, coffee, and other stimulating as well as irritating articles of diet should be eliminated. Constipation invariably accompanies this group of cases and should be very carefully watched. This evil is best combatted by a carefully selected diet, which should include much fruit, green vegetables, bread made of whole wheat, and, if necessary, prunes stewed in water that contains a small bag of senna, the amount being graduated so as to make it palatable to the patient. After such a case has been carefully studied to eliminate every possible physical cause, and the proper régime has been instituted, it may also be necessary to use some drug. The most valuable at the present time at our command is pheno-barbatol. For children under 6 years of age, a quarter of a grain morning and night will invariably be as efficient as larger doses.

PSYCHOTIC SYMPTOMS AND DISCUSSION.

CASE No. 24.—A mother brought a lad of 4 years to the clinic because of persistent masturbation and stubbornness. An analysis of the case revealed a complicated situation. The family history disclosed tuberculosis on both sides of the family. The general background was poor and unstable. The maternal relatives and the patient's immediate family were dependent upon public aid.

The household includes a father, who is in poor health, is listless, and plays only a passive part in the management of the home; and a feeble-minded mother, who inconsistently disciplines the children, exaggerates their difficulties, inspires fear, is threatening in her attitude toward the patient, shows marked favoritism for a younger sister, and is openly antagonistic toward the boy, so much so that he seems apprehensive and always on his guard when in her presence. In addition to the above-mentioned members, there are an aunt and an uncle, the latter adding to the difficulty by continually teasing the youngster and calling him "sissy."

Further study of the case showed that the boy had been much attached to his grandmother, with whom he had spent much time. She died in January, 1922. At the time of her death, he stayed with the family upstairs. He cried bitterly for her, saying, "My grandma's gone." He was told by his mother that grandma had gone to New York. It was not until two months later, however, that he told his mother that his grandmother was dead, that she "went down a big hole." During the last year he has talked incessantly of his grandmother. Whenever he gets a pencil he writes letters to her, often says he hears his "grandma calling him"; and when punished, he says, "I'll go to grandma." He has called for her in his sleep. His mother at times

finds him gazing at her picture and holding imaginary conversations with her; and when his mother interrupts him he is very angry with her, says he hates her, tells her to get out and stay out, and even tries to strike her.

The mother claims his attitude has changed completely since the grandmother's death. Whereas formerly she had no fault to find with him, she says that he now cries for the least little thing, has become ugly and bold, and is unkind and disagreeable to her.

From the account given by the mother one felt that the child presented certain quite malignant symptoms from a mental point of view and was in need of careful study and supervision.

The boy is perfectly normal physically but has many personality defects in his make-up. He is very jealous of his little sister and selfish with her, probably because his mother openly favors her. He holds a bitter, antagonistic feeling toward his mother and says that he hates her, while she interprets everything he does as being "fresh and bold" and says she is too disgusted with him ever to bother to praise him. His uncle's teasing makes him feel inferior, and he resents being called "sissy." He prefers to play dolls and games about the house, and it is not surprising to find that he has always been kept close to his family and not allowed to play with other children. He is afraid of the dark and cries out in the night that pigeons are biting him. His mother admits that she has at times frightened him in order to make him obey. He wets his clothes and has temper tantrums.

In the treatment of this case there are several factors to be dealt with, the most important of which is the mother, who must be reeducated in her attitude toward the patient and in her methods of discipline; the father must be made to realize his responsibilities; and last, the child must be educated to meet his problems in a more satisfactory manner.

The treatment consisted of frequent visits to the clinic and long talks with the doctor. The mother's attitude was changed, masturbation was stopped by means of diversion and substituting other interests, the child was desensitized to the dark through education and through his love for approbation, enuresis ceased with the institution of routine measures, the boy was allowed to play outdoors with the other children, and he is no longer teased or called "sissy." The child within a few months made a perfectly satisfactory adjustment to the problems of his home and his play life.

Comment.—The foregoing case is not particularly different from the other cases cited, excepting for the reaction of the patient to the death of his grandmother. With his playmates he met the situation in a fairly satisfactory way. He would talk about making trips with them to New York to see his grandmother, apparently refusing to think of her as being gone in the sense that she would never return, and undoubtedly lessened the sting by handling the situation as we might have expected a child to do. With his mother he apparently faced the question openly and frankly, and his antagonism toward her indicates that he felt she was responsible in some way for the grandmother's death. He stated that the grandmother was "in a hole in the ground"; this was his conception of death, the child having none of the conceptions of the hereafter which those his age usually entertain and which are essential in helping them face such sorrowful situations during their early years. When alone, however, he withdrew more completely from the realities surrounding the situation and carried on these imaginary conversations. If these symptoms had been presented in a case 10 or 15 years older, we should have been inclined to feel that we were confronted with rather definite psychotic symptoms, but in children it is extremely difficult to separate the products of their daydreams and wishes unfulfilled from symptoms which have a more grave significance.

There is no cause for alarm if the children have playmates of an imaginary character or if they hold conversations with their dolls or other toys. Not infrequently their own personalities split up temporarily so they are dealing apparently with two or three distinct individuals at the same time, asking and answering questions, praising one and punishing the other. It is these more imaginative children who make up the dreamers of later life, some of them achieving success because of these dreams, others falling by the wayside, unable to cope with their more materialistic brothers.

It is only when the child meets by these definite retreats some definite problem which has made unusual demands upon his powers of adjustment, that there is cause for concern. Here it indicates, perhaps, a type of reaction which may be developed and utilized later in life to the disadvantage of himself and all others concerned.

FEEBLE-MINDEDNESS.

Although the problem of mental deficiency is not one that concerns the habit clinics to a great extent, yet one can hardly pass over the subject without a brief comment. We are all cognizant of the fact at this time that in dealing with the feeble-minded group en masse it is not the intellectual deficiency in the great majority of cases that accounts for their social maladjustment but rather their emotional instability. This statement, of course, applies to the high-grade imbeciles and morons and not to the low-grade imbeciles and the idiots, these cases obviously needing institutional care.

With reference to the value of intelligence tests as a means of determining the intellectual equipment of the preschool child the following questions must be answered:

Are intelligence tests of value with young children? If so, are they of sufficient value to warrant their cost? To answer these two legitimate questions one must consider both the difficulties and the advantages involved.

Difficulties in giving tests to children under 6.

(1) Considerable time is required to establish friendly relations with the child. Particularly is this so with the conduct cases which come into the habit clinic. Also, establishing friendly relations is no guaranty that they will continue. (2) Not only must the child be won over, but the mother's intelligent cooperation and interest must be secured. The mother who precludes the examination with "He is stubborn and won't do a thing unless I'm right with him," offers every incentive to her child to do nothing whether she be present or absent. And when a child refuses to answer any question unless one of similar nature is given to the mother first, certainly a point of diminishing returns can easily be reached. (This type of child, incidentally, very frequently has an intelligence quotient between 110 and 130.) (3) It is absolutely essential to have a clinical psychologist who has had enough experience and has sufficient imagination and flexibility both to elicit maximum results and to evaluate results from children who have not had the standardizing training of the public schools. Young children who come to the clinics are often shy and reticent, afraid of new surroundings, indifferent, or inattentive. They may come from homes where little training or stimulation has been offered them. They may have language difficulties. All these factors make it even less practicable to apply mental tests in any rule-of-thumb manner than it is with older children. If they are so applied, a shy, neurotic child of superior intelligence may be branded as defective or backward. (4) A fourth difficulty lies in the fact that there are relatively few standardized tests available for clinical use with small children. Nonlanguage tests, particularly, are needed. Much must be left to the examiner in the way of checking test results, in finding the child's interests and activities at home, his information, etc. If a child is worth examining at all as full a sampling as possible should be made.

Advantages of these examinations.

(1) Unfortunate and deficient home training is shown up by these examinations at an age when those trends of mental development which are stunted can be stimulated. This implies the possibility in many cases of preventing special disabilities and intensifying special abilities. The child who shows underdevelopment in ideational or verbal fields can be given special story-telling advantages—can be read to more. The child with inferior manual ability can be given more and better manual opportunities. (2) Children who have unusual precocity of a specialized type (for music, color, etc.) or of a general sort may have this precocity appreciated and fortunately developed. (3) Children examined before starting public school can be put into special classes to see how much of the retardation is real and how much apparent—thus avoiding (a) the undesirable sequelae of early school failure for the child in question, (b) the clogging of normal primary grades, and (c) the stunting of a precocious mentality. (4) It is quite essential to successful therapy with neurotic children that their intelligence be known. Obviously the feeble-minded and the precocious can not be given the same treatment.

Are mental tests on young children then worth the effort? If given by an inexperienced person for statistical purposes (mental ages, intelligence quotients, etc.) distinctly "no." If given by a person alert to the difficulties and possibilities, they can be of such real constructive value that they can not be omitted from any progressive program of juvenile mental hygiene.

We have already indicated that there is a certain group of mentally deficient children who have greatly profited by the treatment instituted at the clinic. On the other hand, it is quite obvious that cases such as the following need care and supervision in an institution.

CASE No. 25.—A lad, 4½ years of age, was brought to the clinic because of difficulty in "making him mind." He is hyperactive all day long, wets his clothes during the day and the bed at night, frequently soils himself, is very destructive, pretends to be loving his mother and yet will hit her without provocation, and is unable to speak plainly. He sleeps poorly; whenever he wakes up he wants something; arises and remains up regardless of the time. He goes to bed at 6, for example, and gets up at 3 or 4 in the morning and causes a great deal of disturbance by waking everybody in the household.

In the clinic room he was extremely busy and active, pushing up windows, closing them, sweeping the floor, trying to get into his mother's bag, pushing the chairs about, and scuffling his feet while his mother sat by, constantly yelling at him and threatening him. Whenever he came within her reach she gave him a whack whether the occasion demanded it or not. She said, "There is no other child in Boston that gets as many lickings as he does. He is black and blue all the time from the strap." He is absolutely lacking in fear, and punishment has no effect upon him. Immediately after the punishment he laughs and is as friendly as ever.

During the psychological examination he was restless and destructive (throwing anything away in which he was not interested), and it was impossible to hold his attention. He was unable to follow the simplest directions. His intellectual equipment, which was difficult to evaluate in figures, was obviously low.

CASE No. 26.—The foregoing case does not present the serious problem of mental deficiency presented in the case of a little girl 13 years of age whom I recently saw in jail, held for trial on account of pushing a little boy 4 years old into the water and causing his death.

The family background in this case was particularly bad—poverty, ignorance, and vice, each play a part. For a long time the patient had been recognized as a menace to the community, and efforts had been made by the Society for the Prevention of Cruelty to Children to have her cared for in an institution. The mother, however, resented any interference from outside, and the case was allowed to drift along, one unhappy incident following another until this final tragedy occurred, which demanded the attention of the law.

It was said that two years before, while in bathing, she had held a youngster's head under water by stepping on it, until the youngster was nearly drowned. A year before, she voluntarily had sexual relations with a man who was an attendant at a cemetery near-by, and at frequent intervals less serious evidences of her mental incapacity were brought to the attention of the family and various social organizations.

In the psychological examination she graded to a mental age of $9\frac{1}{2}$ years, showing a marked scattering from the 5 to 15 year old tests. Her emotional reaction during the examination, however, was a fair criterion of her irresponsibility.

When first visited in the jail she was very much concerned over the fact that she was being detained and could not go to the beach with her aunt. She showed little or no concern about the death of her playmate or what would eventually happen to her. She did, however, manifest some anxiety about what the deceased lad's older sister would do to her as she had threatened her before she had been sent to jail.

At the time of the next visit she was very much upset because she was not allowed to have the papers in order to read about herself and what had happened. It was almost impossible to hold her attention on any subject as she would constantly revert back to the fact that "she wanted to read about herself and see what it said" and "the other prisoners who had the papers wouldn't permit her to see them." This lack of emotional response and the absence of concern regarding the youngster whose death she had caused are quite characteristic of many of the higher-grade mentally deficient individuals, and it is this insensitiveness to praise and blame and lack of ability to learn from previous experiences which makes them such a menace to society and demands that some type of institutional training be given them for a rather indefinite period. Many of these individuals, however, eventually become stabilized through institutional care and are able to make satisfactory adjustments in the community in later life.

This case was disposed of by commitment to an institution.

CONCLUSION.

In closing, a brief but more general picture of the habit clinics and their growth will perhaps be of interest. Since November, 1921, when the first clinic was started with a staff consisting of only one physician, in attendance one-half day a week, to the present writing (August 15, 1923), a period of less than two years, six clinics have been organized in the State of Massachusetts—three under the Community Health Association of Boston and three under the department of mental diseases in the division of mental hygiene. Two more will be added to the latter group by November 1, 1923.

At the present time the staff consists of two psychiatrists, one spending six and the other three half days each week, two full-time social workers, one psychologist on half time (provision for another on the same schedule has already been made), and two full-time stenographers. There are also several persons who have done volunteer work in social service and psychology, and very recently arrangements have been completed for the habit clinics to take two students from a well-recognized school of social service in order to give them practical training.

During the last year 160 cases have been registered, of which 130 have been completely studied and worked up. It is too early as yet to evaluate properly the work that has been done. The general co-operation has been excellent when one considers that many of the problems treated at the habit clinics have been called to the attention of the parents by a visiting nurse or social worker or perhaps by one of the workers at the settlement house, and that the bringing of the patient to the clinic was not spontaneous on the part of the parent. Of parents bringing children to the clinics, 73 per cent have cooperated well, but with 27 per cent the cooperation was considered poor. In only 19 cases were the results discouraging and no evidence of improvement shown. Of these discouraging cases, 12 came from families where cooperation could not be obtained; in only 7 cases in which the cooperation from the family was good was failure recorded. Of these seven cases, four were epileptics, one a stammerer, one a jealousy case, and the other a case of temper tantrums.

It is of practical importance as well as of interest to note that such problems as difficult feeding, poor sleeping, or enuresis—problems which invariably responded to treatment most readily—were those which most concerned the parents, while the more fundamental difficulties concerning the personality of the child—phobias and mental symptoms—were minimized or perhaps remained quite unnoticed by the parents. For example, only 2 cases in which fear was considered the problem were brought to the clinic by the parents, whereas examination revealed 24 cases in which fear was the essential factor. Therefore, in the application of psychology to therapeutic efforts, the task was made less difficult by first treating the problem about which the parent was most concerned and which, as stated, responded to treatment most readily, thus obtaining cooperation from the parent and being enabled to carry on the study of the more difficult and fundamental problems. It is not at all uncommon to get most encouraging reports from the parents on the problem of enuresis or on feeding difficulties at the end of the first two or three visits, but many of the cases showing personality defects are still under treatment after a period of months, as some of the cases cited indicate.

Of the 130 cases studied, 76 presented extremely difficult and complicated social problems. *Poverty*—a lack of sufficient funds to provide the absolute necessities of life, producing a situation demanding help from relief agencies—was found in 36 cases. *Disease*—incapacity of one or more members in the family sufficient to interfere not only with the efficiency of the diseased member but with the family life as a whole—occurred as a social problem in 36 families. *Ignorance*—according to Southard and Jarrett, not only a lack of that knowledge necessary for the management of the home and family situations but also erroneous, preconceived ideas regarding the means and methods of running the household—was the stumbling block in 43 families, in 6 of which the mother was feeble-minded. *Vice*—to a very large extent, gross sexual immorality on the part of one or both parents which has brought about the disruption of the home—was found in 12 families.

From the foregoing the necessity of studying the social situation carefully and utilizing every agency which is in a position to contribute to the solution of these social problems becomes quite obvious.

For this reason it is essential that the organization to which the habit clinics are attached be closely affiliated with all the other social agencies. This prevents a duplication of effort.

There can be no question as to the practical value of clinics whose chief concern is the study of the mental health of children. Not only should they be concerned with the more general aspect of the child's life that is usually interpreted in terms of undesirable conduct, but there is even greater need to study the child subjectively in his environment so as to get a better understanding of the more intangible factors that account for the personality defects which render many individuals incapable of making necessary economic and social adjustments in later life. It is not necessary to seek justification for the existence of such clinics in speculations regarding the prevention of obviously mental diseases. We have only to turn to the results obtained, month by month, for encouragement and stimulation in carrying on this practical demonstration of mental hygiene. One feels that the time is not far distant when every medical and social organization dealing with problems of children, whether concerned with the physical aspect of the child's life or the more directly social aspects such as relief and placing out, will consider a personality study an essential part of the case history.



APPENDIX.—HABIT-CLINIC OUTLINES.

TENTATIVE SOCIAL-SERVICE OUTLINE.

1. Identifying sheet.

Name and address of patient.
Name, birthplace, age, occupation of father.
Maiden name, birthplace, age of mother.
Religion, home condition (good, bad, or fair).
Date of birth of patient, date of investigation.
Statement of social problem.
Statement of adjustments made.
Report from the confidential exchange.

2. Address sheet.

Enumerate the members of the household and their ages.
Addresses of all persons associated with the case.

3. Informant sheet.

Description of all persons interviewed (with exception of professional people).

4. History.

A. Patient's name.
B. Referred by.
C. Why referred.
D. Family history.

a. Paternal and maternal.

Grandparents, uncles, aunts, and parents, stating race, country, length of time in America, education, occupation (type of work, wages, length of positions held, reasons for discharge, etc.). Interests, habits, disposition, characteristics (drink, etc.). Health, diseases (tuberculosis, cancer, neurotic taint, accidents).

Marital relation of parents.
Age at and causes of deaths.

E. Siblings.

Age, education, disposition, character, interests, habits, work (positions held, wages), health, diseases, neurotic taints.

F. Personal history.

a. Prenatal.

Financial and health condition of mother during pregnancy. Any mental or physical elements of strain.

b. Birth.

Date and place, normal or instrumental, labor difficult or prolonged. Breast or bottle fed.

c. Development.

Age of teething, walking, talking.

d. Habits.

1. Sleeping: Restless or quiet, dreams, walking or talking in sleep, "night terrors," number of hours of sleep, naps.

2. Eating: Any nutritional difficulties as infant, appetite, diet, special likes and dislikes, eating between meals.

3. Enuresis: Night or day, predisposing causes, sphincter control.

4. Masturbation: Any sex difficulties, sex knowledge, activity, interest.

Incidents of special importance.

5. Thumb sucking, nail biting, tics, choreic movements, stammering. Personal cleanliness, interest in dress, excessive washing, etc.

I. History—Continued.

1. Personal history—Continued.

c. Health.

In general, convulsions (description and circumstances).
Specific illnesses with dates, onset, duration, and after effects. (Reports from physicians and hospitals.)

Weight and height compared with the average.

f. Disposition and character.

Peevish, fretful, or fussy; as an infant and at present.
Friendly, antagonistic, pugnacious, skeptical, jealous, destructive, selfish, affectionate, domineering, attitude toward parents and playmates.

Note: Temper tantrums, fears, lying, stealing, attitude toward animals, sense of responsibility, helpfulness at home. Does patient stay out late at night?

Introvert or extrovert personality.

g. Discipline.

Parental control. Types, consistency, and severity of punishments. Note reason for punishment, by whom administered, effect upon child. (Give specific instances.)

h. Play life.

Type of play, games, toys. Fondness for play.

Playmates preferred, age, character, special chums. Any aversion for either sex. Clubs, athletic interests.

Play outdoors or in house. Opportunities for recreation afforded in the home, or with the family.

Movies, theaters, excursions.

Special interests, such as handwork, sewing, gardening, etc.

i. Intellectual life.

Nursery, school, or kindergarten, age of admission, progress. Relationship with schoolmates and teachers. Activity, interest in environment. Special interests in reading, writing, collecting stamps, etc.

Mental age and I. Q.

G. Religion—Religion of family, church, attendance at Sunday school, interest in and understanding of religion.

H. Relationship existing between members of family.

Between father and mother. Parents' attitude toward children, favorites, etc., between the children. Do they quarrel or are they friendly?

Note jealousies, special antipathies. Patient's attitude toward other members of family, and their reactions toward him.

I. Environment.

Description of neighborhood and dwelling.

Social status.

Sanitation and condition of home.

Number of rooms, and sleeping accommodations.

Rent. Financial condition (stating exact income).

5. Outstanding social problems.

6. Plan of adjustment.

7. Summary giving story of case in brief.

8. Treatment.

Make statements accurate, precise, and as succinct as possible, giving illustrative incidents, quoting where necessary or important, and verifying all significant information.

TENTATIVE OUTLINE FOR PSYCHIATRIST'S EXAMINATION.

1. Identifying data.

2. Problem.

3. Parents—Personality—Personal history.

Make the account precise yet sufficiently full to enable one to see, as it were, a "longitudinal section" of the child's past. Conserve a chronological order as much as possible and in so far as it is consistent with the date to be recorded under each of the several subdivisions.

4. Early life.

Begin by giving exact date and place of birth. Give condition and social status of parents at time of conception, condition of mother during period of gestation, pregnancy welcome or unexpected, obstetrical factors. Infancy and childhood normal? Was early physical and mental development adequate? (Did he sit up, creep, walk, and talk at the proper age? Was dentition normal? etc.) Demands for care.

5. Illness and accidents.

General health, childhood diseases with special reference to measles, mumps, varicella, and pertussis. Scarlet fever, diphtheria, typhoid fever, pneumonia, pleurisy, sunstroke, "heat exhaustion," indigestion, constipation, rickets.

Head traumata and accidents—how, when, where, unconscious, how long in bed, incapacitated, medical or surgical attention, surgical operations. Give date, type of operation.

Any "fits," fainting spells, "nervous" attacks, or "breakdowns?"

Chorea. Defective sight, vision, speech.

6. Habitual reactions.

Weak, peevish, fussy, fretful child? History of sphincter control, any bed wetting. State when overcome, frequency, antimeasures, its persistence, etc. Any "general nervousness," neurotic thumb sucking, nail biting, sand eating, finickiness about food and eating habits, good or bad sleeper, nightmares, "night terrors," fits of temper, obedient or disobedient, somnambulism, talking in sleep, dreams, noting frequency and type ("contemplative," those of occupational cast, "hypnagogic," pleasant, unpleasant, recurring). Tics. Voluntary muscles. Respiration, stammering, mannerisms, hysterical outbreaks, drooling, spitting, vomiting.

Asocial habits. Sex assaults. Lying, stealing, truancy, fire setting, destructiveness.

7. Schooling.

Year he began and year he left. Attendance regular or irregular.

Grade reached. Type of scholar—bright, average, dull, stupid, failures of promotion. Any truancy, suspensions, or other difficulties.

8. Make-up, psychobiological: Inquire into the patient's habitual reactions (mental and physical) to his environment and social demands. In recording, cite illustrative facts rather than merely applying adjectives. Endeavor to determine the nature of his personality. In order to formulate an estimate of a patient's personality, certain traits and factors are to be borne in mind, and the various changes which these traits and factors have met or undergone during the patient's life.

(a) Disposition: Frank, open, or reserved, reticent, and shut-in; tendency to talk about himself, to unburden or not; important and boastful, or overconscientious, or inconsequential, fickle, and aimless; imaginative; fantastic or matter-of-fact; truthful or liar; fussy, finicky, self-conscious, overscrupulous, chronic inaptitude. Aggression (energetic or lazy, hustler or intermediate), self-reliant or dependent, conceited or modest, submissive or self-assertive, courageous or cowardly? Cruel, suspicious, jealous, timid, domineering, selfish, pugnacious.

(b) Temperament: Light-hearted, optimistic, or pessimistic, anxious, worrisome, and looking on the dark side of life; periods of despondency or buoyancy without obvious cause; mood reaction toward success and pleasurable occurrences, on the other hand, toward failures, disappointments. Contented or discontented, tendency to brooding, irritability, ungeniality, irascibility, tantrums.

(c) Instinctive demands: Friendship—natural, makes friends easily and freely, or reserved and peculiar about it. In the realm of the "love instincts"—sex instincts, heterosexual or homosexual. Time and conditions of acquiring sex information. Any unusual eroticisms, exhibitionism (self), exhibitionism (others), thigh squeezing, toilet interests. What are his attachments to his parents or other familial influences? Any definite sex instincts?

(d) Intellect: Psychometric test. Parental statements. Has he shown adequate initiative and perseverance as revealed in his play? Attention, concentration, interests, special ability or disability with reference to organized tasks. General knowledge. Interest in environment. Teachers' statements.

(c) Adaptability: Get along well with others, sociable or tendency to get by himself, bashful, shy, selfish, or kind-hearted, tactless, faultfinding, stubborn, trustful, or suspicious, holding grudges, seeing slights easily when none are intended? What are his general interests, and what is their distribution? Does he get much satisfaction out of life? Much wanderlust? Any real or fancied sources of worry or infelicity?

Bearing the foregoing enumeration clearly in mind when examining a case usually permits one to group the patient's personality quite adequately, as follows:

Seclusive type (shut-in): Is absent-minded, lacks interest, plays but little and in half-hearted manner. Is self-absorbed, is a daydreamer and shuns contact with others to noticeable extent. Is shy, timid, distant, often apprehensive and even suspicious. Is silent and uncommunicative, never a leader and ever in need of urging.

Egocentric type (self-centered): Is selfish, defiant, aggressive, opinionated, distrustful, inconsiderate, resentful, stubborn, and conceited. Frequently wears a "chip on his shoulder," rarely admits an error, has a tendency to blame others and to hold grudges. Is superficial, often supercilious, frequently criticizes without much reason, is prejudiced, has little feeling for others, and is not infrequently cruel.

Overactive type (hyperkinetic): Is restless, impatient, boisterous, mischievous, always on the go and very much a "busybody." Speaks rapidly, is talkative, and is in general nervous and fidgety. Is always ready to play pranks and rarely completes a task undertaken.

Underactive type (hyperemotional): Is sensitive, impulsive, petulant, and oversuggestible. Is vacillating, easily discouraged, and changeable, being inclined to be gloomy at one time and excessively jocular and frivolous at another time. Is subject to "blue spells," laughing and crying spells; temper tantrums, much worrying, and to "ups and downs" generally in mood and attitude.

Neurotic type (prepsychoneurotic): Is finicky, panicky, indecisive, over-scrupulous, punctilious, fastidious, inattentive, unduly anxious, and often forgetful. Is hesitant, backward, easily embarrassed and annoyed, and often complaining about trifles. Frequently is a "goody-good," odd, queer, with many imperious ideas, fears, and even phobias.

There is naturally an overlapping of the types here enumerated. Likewise, all of the traits do not occur in one individual.

Desirable personality traits: Kind-hearted, sympathetic, considerate, appreciative, and responsive. Industrious, dependable, and persevering. Accepts authority.

Special abilities to be noted: Mechanical, domestic, academic. Musical, artistic (sketching and drawing). Good manual dexterity. Athletics.

When other special abilities occur, please specify.

10. Psychiatrist's summary. Check up the following symptoms:

SYMPTOMS.

A. Disturbances of sleep.

Dreams—frequency, vividness, repetition, affectivity.

Nightmares.

Restlessness—motor, mental.

B. Elimination.

Urination.

Defecation.

Drizzling.

Spitting.

C. Habits relation to food.

Perverted tastes.

Vomiting—persistent or spasmodic.

Regurgitation.

Refusal.

Demands to be fed.

Finicky regarding food.

D. Sex knowledge (interest).

Abnormal reactions (quality and quantity).

Masturbation—imitative, accidental, trained.

Toilet interest.

Exhibitionism.

Excessive sensitiveness about matters pertaining to sex.

Thumb sucking (complicated).

Anal and genital irritations.

E. Asocial.

Truancy (from home or school).

Lying—purposive, fantastic, jocular.

Stealing—value, from whom, motive.

E. Asocial—Continued.

Destructiveness—amount and value.

Fire setting.

Sex assaults.

F. Convulsions.

Tics (voluntary and involuntary).

Chorea.

Respiratory.

Stammering.

Baby talk—mispronunciation.

Hysterical manifestations.

Mannerisms.

Fainting spells.

Momentary losses of consciousness.

Hyperactivity.

G. Personality traits.

Shyness.

Negativism.

Lack of confidence.

Selfishness.

Jealousy.

Pugnacity (tempers).

G. Personality traits—Continued.

Fearfulness.

Hatred.

Unusual attachments.

Self-assertiveness.

Day dreaming.

Cruelty.

Demand for attention.

Dominicering.

Self-centeredness.

H. Mental manifestations.

Phobias.

Depressions.

Apathy.

Paranoid tendencies.

Elation.

Hypnagogic hallucinations.

Intraversion.

I. Intelligence status.

School progress.

General knowledge.

Ability at play.

Rapidity at learning.

Retention.

Other observations, worthy of note, are the contact of the child with the father, mother, and his devotion to the parents and other children in the family, the home discipline, the objective interest of the child and his accessibility and willingness to cooperate. It must be borne in mind that not only are there marked differences in the native intellectual ability of every child, but there are definite inherent abilities and disabilities which tend toward success or failure as well as the ever-variable social heritage with which the child has to contend.

REPORT OF PSYCHOLOGIST.

Date.

Age.

Attitude. Noting child's willingness to do what is asked of him; his effort; physical activity; stream of talk; and anything unusual or bizarre. Particular notice should be given to factors influencing test results.

Attention. Degree of distractability; effect on test results.

Family background. Are there language difficulties and limitations? Educational status of the family. Interests and instruction which would influence type of child's intellectual development.

Developmental history. Physical growth. Special handicaps and illnesses.

Intelligence.

(1) Tests.

a. Verbal-ideational sort. M. A. I. Q. Peculiarities of development.

b. Nonverbal performance tests.

(2) Information.**(3) Interests—at home, at clinic.****Summary.**

(1) Statement of general ability (evaluation of test results in the light of above data).

(2) Special proficiencies and deficiencies.

Recommendations (e. g., special training necessary to favor special abilities or minimize special deficiencies).

SUMMARY.**1. Willingness.**

A. Enthusiastic eagerness for the experiment.

B. Actively enters into the experiment.

B. C. Normal attitude; because proper.

C. Because must; as a disagreeable task.

D. Active objection.

2. Effort.
 - A. Utmost capable.
 - B. Perceptibly exerts self.
 - B. C. Normal effort; neither indifferent nor overconcerned.
 - C. Perfunctory, embarrassed, or distracted.
 - D. Apathy.
3. Physical activity.
 - A. Marked agitation or excitement.
 - B. Above normal; fidgets.
 - B. C. Normal, including drumming and stretching.
 - C. Only as examination demands.
 - D. Notably retarded.
4. Speech.
 - A. Talkative, interrupting examination.
 - B. Above normal, spontaneously on irrelevant subjects.
 - B. C. Normal, conversational.
 - C. Does not speak spontaneously.
 - D. Replies only after much urging, or not at all.
5. Attention.
 - A. & B. Preoccupied with experiments; little if any interference from stimuli ordinarily distracting.
 - B. C. Normal; attention to other things may be shown but not so as to impair efficiency in experimental tasks.
 - C. Distracted by chance extraneous stimuli or by own ideas, may comment on these irrelevantly during the examination but attention readily reverts to experiments.
 - D. Abstracted, difficult to get attention to experiments; keeps reverting to topics of more immediate moment to him.
6. Comprehension of directions.
 - A. & B. Grasps experimental tasks before usual instructions are completed.
 - B. C. Requires no elaboration of usual instructions.
 - C. Grasps ideas after little supplementary explanation.
 - D. Comprehends tasks only after unusual elaborations or not at all.

PSYCHOMETRIC TEST (KUHLMANN-STANFORD).

Name_____ Sex_____ Date_____

Age_____ M. A._____ I. Q._____ Birth date_____

Schooling_____ Nativity of parents_____

- | | |
|---|---|
| <p><i>III mos.</i> 1. (a) Hd. to mouth. (b) block r. and l.</p> <p>2. Snapper, 2 trials ea. ear. Clap, 1 ea. ear.</p> <p>3. Bin. coord. r. to l. and b., up, down, diag.</p> <p>4. Eyes to light, b. to s. sev. trials.</p> <p>5. Winking.</p> <p><i>VI mos.</i> 1. (a) Bal. head. (b) Sit supported (both).</p> <p>2. Turn head to sound.</p> <p>3. Cube and pen on palm r. and l.</p> <p>4. Prolong. hold obj., r. and l.</p> <p>5. Reach for seen obj.</p> <p><i>XII mos.</i> 1. Sit and stand un supp.</p> <p>2 Spont. Vocab., (a) 2-3 Syl. (b) Imit. syl. (hist.)</p> <p>3. Imit. rattle, bell, head. 1 of 3</p> <p>4 Mark w. pencil, w. and wo. instr.</p> <p>5. Recog. obj., reaching. (preference)</p> <p><i>XXIV mos.</i> 1. Point to pict. of obj.</p> <p>2. Arms, clap, palm, turn. 3 of 4</p> | <p>3. Bring ball, throw, sit in chair. 2 of 3</p> <p>4. Copy circle. 1 of 3</p> <p>5. Wrapping from candy.</p> <p>*†III. 1. Eyes, nose, mouth, hair. 3 of 4</p> <p>*†2. Key, penny, knf., watch, pcl. 3 of 5</p> <p>*†3. Pictures, enum. 3 obj. in 1 pc.</p> <p>4. Sex. Correct first in qu.</p> <p>*5. Last name.</p> <p>*6. Dog, cat, hot. 1 of 3</p> <p>a-1. Ff. 641, 352, 837. 1 of 3</p> <p>*†IV. 1. Compare lines, 3 of 3 or 5 of 6</p> <p>2. Discr. forms. 7 of 10</p> <p>*†3. Count 4 pennies. no err.</p> <p>*†4. Copy square, pencil. 1 of 3</p> <p>*†5. Sleepy, cold, hungry. 2 of 3</p> <p>6. Ff. 4739, 2854, 7261. 1 of 3</p> <p>a-1. Jhn., trn., cntry. 1 of 3. 2 w. 1 err.</p> |
|---|---|

- *†V. 1. Compare weights. 2 of 3
 *2. Colors. no err.
 *†3. Aesth. comp. no err.
 †4. Chr., hrs., frk., dll., pnel., tbl.
 4 of 6
 †5. Div. rectangle. 2 of 3. 1 min. ea.
 *6. Key, door, box. no err.
 a-1. Age.
 *†VI. 1. R. hd., l. ear, r. eye. 3 of 3,
 5 of 6
 *†2. Mutil. pict. 3 of 4
 *†3. Count 13 pennies. 1 of 2
 *†4. School, fire, car. 2 of 3
 5. 5, 1, 25, 10. 3 of 4
 6. Mouse, fshg., straw. 1 of 3. 2 w.
 1 err.
 a-1. A.M., P.M. Correct first in qu.

- *VII. 1. Fingers. no err.
 *†2. Pictures, desc. over $\frac{1}{2}$ desc. 2
 of 3
 3. Ff. 31759, 42835, 98176. 1 of 3
 4. Bow knot. 1 min. sg. b., $\frac{1}{2}$ cr.
 *†5. Fly-butterfly, etc. 2 of 3
 *†6. Copy diamond. Pen. 2 of 3
 a-1. Days week. no err. 15 secs.
 2 of 3 cks.
 †a-2. Fb. 283, 427, 958. 1 of 3

- †VIII. 1. Ball and field. Inf.
 *†2. Count 20-0. 40 sec. 1 err.

- *†3. Broken, tardy, hit. 2 of 3
 *†4. Wood, coal, etc., 2 of 4
 5. Bilb., tgr., ftbl., sldr. 2 of 4
 *6. Vocab., 20 words.
 a-1. 1, 5, 25, 10, 100, 50. no err.
 a-2. See the little boy. 1 min.
 *†IX. 1. Date, 3 ds. err. in d. of m.
 *†2. Arrange weights. 2 of 3
 †3. 10-4, 15-12, 25-4. 15 secs. 2 of 3
 *†4. Fb. 6528, 4937, 8629. 1 of 3
 *5. Boy, river, ball. 2 of 3. 1 min. ea.
 6. Day, mill, spring. 2 of 3. 1 min. ea.
 a-1. Months. 1 err. 2 of 3 cks. 15-
 20 secs.
 a-2. Stamps. 15 secs.

- *X. 1. Vocab. 30 words.
 *†2. Absurdities. 4 of 5
 †3. Designs. 10 secs. expos.
 4. Rdg. & Rpt. 8 mem. 35 secs. 2
 err. in rd.
 *†5. Opinion, beginning, actions. 2 of
 3
 *†6. 60 words. 3 min.
 a-1. Ff. 374859, 521746. 1 of 2
 a-2. Apple, cat, summer. 1 of 3. 2w.
 1 err.
 a-3. Healy A. 3 in 5 min.

	1. Porteus.	2. Cube Imft.	3. Goddard Adapt.	4. Manikin.	5. Goddard Form B.	6. Mare and Foal.	7. Diagonal.	8. Substitution.	9. Triangle.	10. Healy PC-1.
10										
9										
8										
7										
6										
5										
4										
3										
2										
1										

Porteus 3 4 5 6 7 8 9 10 11 12 (13) 14

Cube Im.

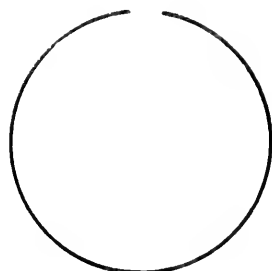
A 1234
 X 12342
 Y 12342
 B 1324

O 1432
 D 1423
 E 13243
 F 14324

G 13124
 H 143124
 I 132413
 J 142341

Healy PC-1.

---Basket (55)-----
 ---B. Window (100)-----
 ---Cat (81)-----
 ---Chicken (58)-----
 ---Dog (64)-----
 ---F. Bird (87)-----
 ---Football (84)-----
 ---Hat (65)-----
 ---Log (52)-----



DEVELOPMENTAL HISTORY.

Name-----	Clinic-----
1. Birth weight.	5. First tooth.
2. Normal increase of weight? Any nutritional difficulties which interfered?	Other teeth.
3. Present weight. (Normal weight for age and height?)	6. First sat up.
4. Illnesses? what? (Special reference to parents' opinion as to whether development (teething, talking, walking, etc.) was thereby delayed or arrested.)	7. First crawled. How long.
Accidents?	8. First walked. Any peculiarities.
Operations?	9. First said "mama"; "papa"; "da-da"; "bye-bye."
Remarks-----	10. First used other words to any extent.

By-----

EDUCATIONAL BACKGROUND.

Name-----	Clinic-----
1. Nativity: Father; mother. Language spoken in home. Do parents speak English well?	
2. Occupation of father; mother. Also previous occupation. Wages.	
3. Schooling: Father; mother; other children. Grade reached. Age of leaving. Difficulty with any studies? What?	
4. Reading: Father; mother; other children. Newspapers, periodicals, books. What? How much?	
5. Reading to children: By either parent; by other children in family or outside of it; by anyone else. What? How much?	
6. Story telling: By anyone. What type of story?	
7. Has child been taught to tend to personal needs? Toilet, at what age? Clothes, at what age? Shoes, at what age? Picking up things, at what age?	
Ask the mother if she attempts to teach child these and other things (be specific) or does she get impatient and do the things herself.	
8. Does mother or father do any hand work around home that child has seen and been interested in?	
9. Anything in family situation which may have influenced trend of child's intellectual development?	

INTERESTS.

Name-----	Clinic-----
At clinic. Child's interest in tests. General alertness.	
Mother's statement:	
What does the child play at home?	
Does he play with other children?	
Does he help or attempt to help with little tasks around the house?	
Is there anything he is especially interested in?	
Interested in toys? In working with hands? Pencil, scissors, etc.?	
Child's statement:	
What do you play at home?	
Do you like to play with other children?	
Do you like to play with boys or girls?	
Do you help your mother? What do you do to help?	
When you grow up, what do you want to do?	
Remarks-----	

By-----

INFORMATION QUESTIONNAIRE.

Name_____ Age_____ Clinic_____

Attitude and cooperation_____

1. III. What is your name?
2. III. Knows eyes, nose, mouth, hair.
3. III. Knows key, penny, knife, watch, pencil.
4. III. Knows sex.
5. III. Knows to enumerate objects in picture.
6. IV. Knows what "big" means.
7. V. Knows age.
8. V. Knows names of colors.
9. VI. Knows right and left.
10. VI. Knows coins. 1—5—10—25.
11. VI. A. M. or P. M.
12. VII. Knows days of the week.
13. What is this? Shoes—hat—stockings—chair?
14. What do you use to sweep with?
15. What do you use to drive nails with?
16. Is it colder in winter or summer?
17. Which is bigger, an orange or a marble?
18. Which is bigger, a pencil or a needle?
19. What is your father's name?
20. What kind of work does he do?
21. How many sisters have you? How many brothers?
22. What are the names of your brothers, sisters, uncles, aunts?
23. Tell me the names of some vegetables.
24. Tell me some fruits.
25. How much does it cost to ride on the street car?

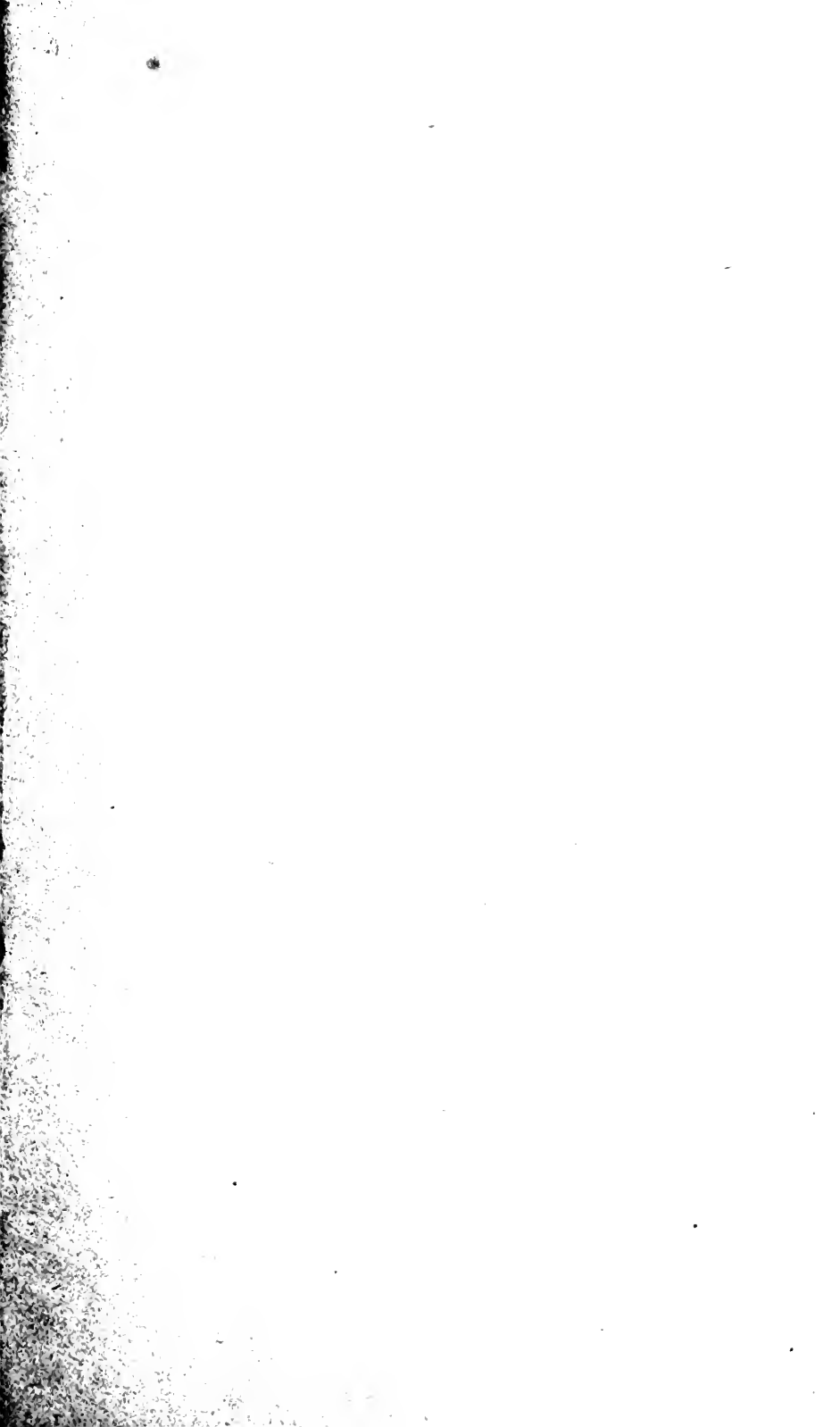
Conclusions_____

By_____









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